

Spring 1972

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CHILDBIRTH & INFANCY

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CATHOLIC CHURCH & BIRTH CONTROL IN LATIN AMERICA

Sociological Aspects of Change & Dependency Among Catholics

INTRODUCTION

The official tenants of the Catholic Church in regard to the planning of human fertility have posed, among other things, a new problem in Latin American Sociology--the problem of dependency. This is particularly related to the personality system of Latin American Catholics. The purpose of our study is to analyze it in the context of religious behavior and from the vantage point of the sociology of knowledge.

Three major assumptions will base our inquiries along this line:

(1) The term 'Catholic Church' can designate two different social systems. The first is Church as "Authority": namely, bishops and clergy who officially voice their teachings and opinions about moral matters. The second is Church as a community of faithful. Sociologically, this second aspect is the paramount expression of the reality which was defined by the II Vatican Council as the essence of the Church, the Christian Community, the "People of God."¹

¹ See, Vatican II, dogmatic constitution on the church, *The Documents of Vatican II*, ed. Abbot M. Walter, S.J. (New York: America Press, 1966) 15.

In regard to Latin America, we understand it as a concept which designates a vast number of sub-systems (Catholic communities) within various national societies of the whole region.

(2) Between these two systems there exists a dialectical process of action. Such a process is dictated by the nature of religious life according to Christian doctrines. The existential concern about the limitation of births in the Christian community is only one instance of the said process--perhaps, more appropriately, a dialectical problem.

Not all Catholics perceive this problem in the same manner. First and most commonly, it all seems to be an "un-thematic" (or non-explicit) concern: an ill-defined search for the control of fertility because of economic, societal, or leisurely pressures.

It is from such a concern of the faithful up to simple awareness among authorities

Paper originally titled, "Some aspects of modern catholicism in relation to birth control in Latin America," and delivered at the 34th meeting of the Southern Sociological Society, May 1971, Miami Beach.

that the process of action continues in order to further on resolved in a synthesis of "thematic" concern or in a reflectively conscious awareness of the Christian community. Our study focuses upon the characteristics of this last step of the dialectics.

In non-professional parlance one could explain what has been said by positing that the Catholics live today under growing pressures for birth control before any official statement of the authorities identify it in terms of Christian life. Once this development takes place, the community ends up with a sort of new acquaintance with the problem. Such a new and deeper internalizing of the problem may or may not answer the teachings and official doctrines of the Church in the sense they were proposed to the faithful.

(3) Third assumption: In regard to the question of diffusion of ideas and of the coming of awareness in developing societies, one is bound to accept the role of the community leaders as paramount. This is due to the fact that the leaders regularly speak for their own communities with legitimate consensus of their members. Equally relevant also, the leaders act as cathartical elements of consciousness in societal problems.

Complementary to these hypotheses, a few thoughts deem appropriate. Any Catholic community of today becomes a segment of an open society. It is otherwise exposed to the knowledge and experiences of the new industrialized bourgeoisie. In this respect, the French scholar, Tabah, points out that birth control in industrial societies has begun because of their bourgeois character.²

The limitation of births may be founded upon an idea most often implicit and never perceived by the actors themselves: namely,

that a large family could enter in conflict with the desire of achieving certain roles and getting a certain status in a society that is undergoing constant transformation.

This explains the phenomenon otherwise detected in many societies of the industrialized world; the limitation of families becoming an important means of upward mobility for the bourgeois-oriented strata.³

The latest figures of Catholics in Latin American national societies (Vatican Atlas of 1967) merely stress the importance of our considerations in view of the trends of change among priests (uncontested leadership) and among Catholics per priest in the Latin American societies.

1. BETWEEN COMMUNITY & AUTHORITY

It was only in the 60's that the Catholic Church came to a new state of affairs in regard to our problem: we may call it the stage of synthesis which is characterized by a new awareness of the problem of population control among all Catholics. Such awareness, still in the process of growth, is manifested in a dialogue within the Church, Church Authority versus Church as a Community. It is also discovered in the dialogue between Catholics and other christians (and with non-christians as well).⁴ Let us trace the said dialogue back to its own sources.

The major contemporary documents (Catholic) of social doctrines, including Pope John XXIII's, namely, the encyclicae *MATER ET MAGISTRA* (Mother & Teacher) and *PACEM IN TERRIS* (Peace on Earth), clearly drew the attention of the Catholic leaders

² L. Tabah, *Contracepcion en el tercer mundo, Demografia Y Economia*, 1 (1968) 282.

³ L. Van Nort, *Biology, rationality & fertility: a footnote to transition theory*, *Social Demography*, eds. T. R. Ford & G. F. DeJong (Englewood Cliffs: Prentice-Hall, 1970) 636.

⁴ B. Haring *La Crisis de la enciclica, Mensaje no. 173* (October 1968) 480.

(clergy and community) towards some aspects of birth control and population policies.⁵

These two documents pointed at one major element of solution of the problem, otherwise subscribed by the Pope as the basic tenet of the Church in regard to birth control. It was namely the respectful approach to the free decision of the married couple in relation to their offspring.

Prior to the Ecumenical Council, several Bishops like Monsignor Reuss (Mainz, Germany), Cardinal Doepfner of Munich and Cardinal Leger of Malines (Belgium), together with scholarly Cardinal Koenig of Vienna, elaborated the same principle of solution in terms of the practice of sacramental life (confession, counseling, etc.) among Catholics.⁶

It is, however, at the time of Vatican II when the stage of synthesis and dialogue clearly showed up: a special commission of advisory character to the Pope was created in order to study the morality of modern contraceptive methods and family planning.⁷ Catholics in general, and most particularly Catholic leaders (some of them even participated in the Commission), turned towards a conscious reflection of the problem more than ever before. What are the consequences of all these developments?

2. A NEW DIALOGUE WITHIN THE CHURCH

Surveys of opinions of lay leaders and Catholic clergy, including Bishops, in Latin America in relation to birth control are only beginning. They came about practically at the time of Vatican II.

In spite of the provisory nature of all answers to the problem at this stage, it is very possible that we can already derive important

sociological observations from one of the most serious attempts to survey Catholic leaders. The core of this study is related to it.⁸

In 1967 FERES* International launched a study of opinions of Catholic leadership in five countries which were thought of as a representative sample of the cross-sectoral and cross-cultural conditions of such leaders in Latin America. All together, there were five hundred persons interviewed in each country, predominantly in urban settings. A stratified random sample was devised according to the census figures of major categories of population. The number of Bishops interviewed is obviously the lower among all categories. A small number of non-leaders was interviewed for purposes of comparison.

This survey was based upon three major hypotheses:

- (1) From a structural-functional point of view man can be analyzed in the frame of a large socio-cultural system which is composed of two parts, one of them, Religion, radically included in the other, the socio-cultural system in general.
- (2) Within such a context, man's behavior follows certain steps (here to be called sectors) of psychic activity, which are:
 - (a) Perception of reality, namely the demographic problem and the norms of the Church
 - (b) Norming and value-setting
 - (c) Existential or living attitude
 - (d) Actual behavior

⁵ Pope John XXIII, *Encilicæ mater et magistra, Acta Apostolicæ Sedis* 53 (May 1961); idem, *Pacem in terris, Acta Apostolicæ Sedis* (April 1963).

⁶ *Mensaje* no. 175 (December 1968) 651-58.

⁷ Haring op. cit., 478.

⁸ L. Lenner, ed., *Poblacion Iglesia Y Cultura: Sistemas en Conflicto* (Mexico: Instituto Mexicana de Estudios Sociales, 1970) 526.

*Federation of Research & Study Centers for the Sociology of Religion, Brussels, Belgium.

- (3) From these premises, the model presented below was developed, bringing together the summary findings of the FERES survey. It juxtaposes the four major steps (sectors) of mental activity regarding the birth control question to the most important configurations (structural) of

human beliefs; namely, the so-called religious and the socio-cultural systems.

It is from the findings expressed in the model that we will, later on, draw the analysis of social dependency.

TABLE II

PREVALENT TRENDS OF RELATIONSHIP BETWEEN THE RELIGIOUS AND THE SOCIO-CULTURAL TRAITS AMONG CATHOLIC LEADERS***

SECTORS (Steps of Psychic Activity)		Religiosity	Other Areas of the Socio-Cultural System*
I.	Perception of reality: i.e. of demographic crisis and church norms	(dubious)	+
II.	Norms and values concerning family planning	+	+
III.	Existential attitudes	-	-
IV.	Actual (concrete) behavior	-	+
Result:	Anomie (Anomic Personality)**	Yes	No (Most Probably)

*Symbols: + = Going along together
- = Conflicting

**If we accept the concept of anomie as the result of conflicts which stress upon the individual, between two norms relative to the same area of behavior.

***Source: Lenero O. Luis (ed.). *Poblacion, Iglesia y Cultura; Sistemas en Conflicto*, IMES (Mexican Institute for Social Research), Mexico, 1970, Ch. 8.

3. TENDENCIES & STRUCTURAL RELATIONS

First, we can speak about higher or lower levels of complementarity and/or conflict as far as perception of reality (population crisis and church doctrines) is concerned. In this respect, religion has a rather dubious impact. That is to say, the individual begins to act without substantial reference to his own religious structure. Everything depends upon the degree of education the persons have received. Even more, in persons who are in the upper levels of the religious system (like bishops, priests and very prominent leaders), it was found that they have a lower perception of reality than the ordinary layman.

Second, insofar as a concern with norm evaluation, there exists a positive relationship between the norms of the religious and of the socio-cultural system. In every respect (structural as well as personal) there seems to take place a rather liberal conception of family planning.

In other words, the position of an actor in the religious system appears linked to a tendency of action (here, judging) which is paralleled by his tendency to judge according to his position in the socio-cultural system, as defined by educational levels. In general, a person who possesses more knowledge of religion and a higher status within the religious system will tend to act in a more liberal way than others. This happens to be a striking parallel to the position of the actor in his own socio-cultural system: more conservative persons (as far as their judgements is concerned) happened to be not so highly educated.

Third, when it comes to existential attitudes among personalities there is a predominance of the religious system upon the socio-cultural. This means that the religious factor has a negative influence in regard to more liberal attitudes and, consequently, the persons who are among the first in the religious system (the Catholic leaders here) will tend to experience more conflict in their own standing; thus, to foster less liberal attitudes (existential living attitudes) in sharp contrast to the growing tendency of accepting

the norms and values of family planning. In this sense (existential attitudes), the socio-cultural system is less defined in its relationships to the religious systems. That may show that education as a factor has a less predictable influence upon living attitudes if compared to religion.

Finally, an open clash occurs between religious and the socio-cultural systems in the avenue of practical behavior. There is, consequently, a negative relationship between religion (as defined by the practice of sacraments, and the actual religious status in the religious system) and inclination towards family planning, and a positive one between education and birth control (education being here the major element defining the status in the socio-cultural system).

A second look at the picture furnishes us with other relevant findings. It seems paradoxical that one could find a positive evaluation of the principles of family planning and a negative stand when it comes to living attitudes and behavior. That can mean that the religious system as it is found in today's Latin America societies is somehow anomic in the sense of producing anomic personalities. This, in turn, feeds back upon the area of perception of reality by the Latin American Catholics. If, on the one hand, the people learn some doctrines or are exposed to doctrines which favor family planning and, on the other hand, the living attitudes (as well as the most important religious personalities) contradict this evaluation, the results are ambivalence in normative standards, looser structures of value-orientation, and weakness in doctrinal closure.

4. CONFLICT WITHIN THE CHURCH

It is interesting that one can see the same weakness in the very papal pronouncement of the Encyclical *Humanae Vitae*:

Pope Paul's Encyclica insists upon fundamental values of love as the basis of marital life, making the dualism between procreation and love disappear as well as the dualism of marriage based upon the biological diversity of sexes and conjugal

society of purely spiritual nature. The Encyclical posits the principle of responsible parenthood as well as the necessity of birth control. And even more the Encyclica does recognize that the demographic problem has a serious incidence upon economic and social development, and this problem is viewed as a part of a total, asking for a correct answer related to all domains of human activity. However, when it comes to the concrete level of action, the Encyclica only allows the method of rhythm which is impractical for the majority and which is inconsistent with the core of the Encyclica's proposition that all uses of marriage should be open to procreation.⁹

It must be recognized, however, that in spite of the papal condemnation of the pill, (1) the Church has acknowledged the rights of human consciences which are commonly recognized as supreme.¹⁰ On the other hand, Latin American ecclesiastical authorities have been reluctant to discuss or to confront this issue except, perhaps, the Chilean bishops. They have been simply praising all papal documents without making any evaluation of the problem.

Probably the most relevant consequence of the present position of the bishops is the fact that it continues to be an obstacle for policies of population and family planning at the national levels, even if the said position may in fact be a break with the past! This is due perhaps to the unquestioned prestige and authority of the bishops and clergy in regard to every issue of national concern in the Latin American countries.¹¹

When we speak of the Latin American societies as 'Catholic Communities' or of the church as a community in Latin America, one is to remember that the consciousness of

'belonging,' the sense and effectiveness of participating in such a community does not occur to the same degree in the various societies or sub-societies, nor in a wide range of settings. There is often a world of difference between the small ranchos and the megalopolis like Buenos Aires or Mexico City.

Nevertheless, something holds true even under those circumstances of variance: the fact that everybody among the Latins are concerned with a definite complex of opinions, folkways and mores. Regardless of whether or not they are supported and tolerated by their church, they are accepted by all members of the society. This proves a minimum of social consensus upon which some generalizations can be made, about people who label themselves Catholics with a conscious belonging to certain societies of ethnic or national character.¹²

Social changes with particular regard to family planning seem to take place with ease and with less strain among educated Latin Americans in general, and particularly among Catholic leaders. A seemingly working agreement does already exist between their religious and their socio-cultural normative mapping. On the contrary, certain conflicting relations are predominantly found between religious and secular or mere socio-cultural behavior.

If that is correct, one is to conclude that the Catholic community appears to suffer from a disfunctionality or atrophy in the system of religious values. This can only make the process of change more painful and lengthy since there will tend to be an increasing lack of articulation between church and society, as the finding showed to be the case among the Catholic leaders (or between their so-called religious and socio-cultural systems).

This phenomenon does not have any counteracting influences in the official stand of the Latin American church and even less in

⁹ Ibid., ch. 4 (Author's italics & translation).

¹⁰ See, *Mater et magistra*, op. cit., para. no. 195.

¹¹ CELAM (Latin American Bishops Conference), *Declaracion de medellin*, *National Catholic Conference News* (US) (9 August 1968).

¹² J. Rivera, *Latin America: A Socio-Cultural Interpretation* (New York: Appleton, Century, Crofts, 1971) 163-66.

the recent pronouncements of Pope Paul (Humanae Vitae). It seems logical to assume, therefore, that contrary to what has been happening in other Christian and more educated Catholic communities of the Western World, the problem of papal doctrine of birth control may not be experienced to any great extent as a problem of church authority. This can happen because the greatest number of Catholics and/or Catholic communities in Latin America have been traditionally experiencing the lack of coherence between doctrinal values and concrete behavior.

5. SOCIAL DEPENDENCY

This leads us to reflect upon the degree of integration of Catholic faith and behavior in Latin American societies, particularly at the level of the personality systems. In his study of sociological dependency, Monzel¹³ points out that Catholics live their religion between two absolutes: God's will (to accept Christian revelation) and church authority (to proceed according to such faith). The latter varies according to the kind of education (religious) and traditional influences in monistic or pluralistic societies.¹⁴

The first absolute is primarily based on faith; the second is bound to certain cultures and is originated in some inherited sets of values. The first becomes unquestionable and universally based upon its own claim; the second one is mythical and culturally grounded.

When a lack of coherence is detected between the postulates of faith and those of authority, some ambivalence and contradiction is to be expected in the life of the Catholics. However, such contradictions are not

generated because of a conflict situation per se. They stem out of the fact that one of the conflicting absolutes (Church authority) is a spurious one—at least from the theological point of view.

It has been already acknowledged that the concept of authority in the church does not have strict sociological analogues derived from the experiences of civil societies.¹⁵ It is most of all a concept of supreme devotion and service to the Gospel by caring for the needed (according to the Christian teachings) on behalf of Christ.

What has followed, though, after the church became an independent institution recognized by the Roman Empire, is a gradual emergence of a new concept of authority (secular and civil) strongly tied with the absolute and uncompromising claim of the church of conveying to men the word of God. Most good textbooks of Church history describe carefully this phenomenon which later parallels, for instance, the legitimation (social) of the role of Pope Alexander VI, as an arbiter for the territorial domain of Spain and Portugal when the colonization of America began. This absoluteness of Church Authority, as a cultural concept, makes the relationship between authority and community not a dialogue between complementary social systems, but rather a confrontation between a community and a monolithic system of control which claims exclusive domain in the absoluteness of the principle upon which both systems are founded—namely, the will of God.

Such a confrontation results in a sort of impasse: not in a synthesis of dialectical nature. In the life of the Catholic community, this impasse becomes apparent in the said ambivalent attitude of the faithful. There is no place for a synthesis of action which could grow into a full sense of coherence, but a wandering from a truly absolute to a pseudo-one. This means a true situation of dependency from something (a

¹³ N. Monzel, *Abhangigkeit & Selbständigkeit in Sozialen Leben* (Koeln: Westdeutscher Verlag, 1951) 30.

¹⁴ Ibid.

¹⁵ J. McKensie, *Authority in the Church* (New York: Sheed & Ward, 1967) ch. 1 & 2.

pseudo-absolute) which is hindering the potentials for human development.

We may occasionally find a parallel conflict in Protestant societies (sub-societies in Latin America). There have been recently several instances of priests burning Bibles in Brazil in opposition to Protestant proselytism.¹⁶ The Protestants emphasize Scripture and its literal interpretation. Blind absolute authority of the Church, versus blind Authority of literal reading!

Recent observations provide us with a hint for further deepening along the line of cross-cultural comparisons. We can say that the same tendencies occur among various Protestant sects, Pentecostals for instance, who still oppose birth control practices in many Latin American cities. Early Protestant thought otherwise is known to have been similar to the Catholic position in regard to this issue.

Hutterites oppose birth control, possibly following the literary interpretation (biblical) of their creed, according to the word of Genesis: "Be fruitful and multiply" . . . (with no concern for human reason!).

¹⁶ Information provided by my colleague Herman Daly, Ph.D., (Economics) Louisiana State University.

If any contradictory relation exists between these absolutes in any level of human activity, like the one we find between norming and value-setting in regard to actual behavior, the result will appear in the form of less coherent religiosity and social dependency, as long as the two absolutes persist in conflict.

Why is this so? A tentative explanation seems to appear in view of the Latin American experience. Given the assumption that one of the absolutes, church authority, is not really a religious absolute, but that it can be rationalized and integrated into other cultural patterns, it seems that Latin American Catholicism and the Latin American rank and file Catholic will be unable to coherently assert himself in all dimensions of his personality and unable to live with full consistency (which is the expression of maturity and self sufficiency) as long as he remains unable to integrate religion and secularity in his daily life: that is to say, to live his religiosity with a rational and conscious behavior. He will assert his religion and religiosity in an irrational manner which by the way is not necessarily a question of Christian faith.

On the other hand, as long as Christian education is low and unstructured, Latin American Catholics will not experience the question of church authority, because its absoluteness keeps feeding back the same sort of dependency that the people are already living with.

TABLE I-A: LATIN AMERICA

CATHOLIC POPULATION
(in thousands)

Country	Total Population 1957	Total Population 1966	Catholic Population 1957	Year of Census	Catholic Population 1966
Argentina	22,146	23,031	20,117	1960	23,031
Bolivia	3,256	4,334	3,087		3,834
Brazil	60,080	86,096	56,190	1960	78,945
Chile	6,495	9,236	5,845	1960	6,956
Colombia	13,150	19,315	12,942	1964	19,315
Ecuador	3,803	5,308	3,584	1962	5,017
Paraguay	1,690	1,869	1,612	1962	1,869
Peru	9,294	12,385	8,545	1961	11,935
Uruguay	2,687	2,780	2,407	1963	2,155
Venezuela	5,900	0,352	5,736	1961	8,178
Guianas	769		769	1960	195
Costa Rica	992	943	943	1963	1,316
El Salvador	2,206		2,182	1961	2,261
Guatemala	3,186		3,094	1964	
Honduras	1,426		1,403	1961	
British Honduras	84		50	1960	
Nicaragua	1,068		1,013	1963	
Panama	895		679	1960	
			(TOTAL C.A.)		<u>12,351</u>
Mexico	28,252	45,701	27,223	1960	<u>37,821</u>
Cuba	6,166		5,620	1965	
Dominican Rep.	2,309		2,290	1965	
Haiti	3,404		2,378		
Puerto Rico	2,353		2,200	1960	16,130
Total Antillas	14,232	23,021	12,488		16,130
Total Lat. Am.		258,434			226,186

TABLE I-B: LATIN AMERICA
Relevant Aspects of Catholic Population

COUNTRY	POPULATION DENSITY PER SQ. MILE	POPULATION DENSITY PER SQ. MILE 1967	TOTAL PRIESTS 1957	TOTAL PRIESTS 1966	CATHOLICS PER PRIESTS 1957	CATHOLICS PER PRIESTS 1966	TOTAL CHURCHES 1966	TOTAL POP. PER CENT URBAN
Argentina	20.4	21.2	5,301	4,805	3,795	9,200	4,489	
Bolivia	7.9	8.9	678	698	4,553	11,200	1,765	
Brazil	16.8	26.1	9,179	10,433	6,122	15,100	25,308	46.3
Chile	21.9	30.8	2,197	2,367	2,660	9,100	2,589	68.2
Colombia	28.7	43.9	3,621	3,926	3,574	8,000	2,817	52.8
Ecuador	32.2	50.3	1,184	1,218	3,027	9,000	1,521	36.0
Paraguay	10.4	13.7	309	317	5,217	9,100	414	36.1
Peru	16.9	24.3	1,673	1,709	5,107	14,000	4,656	47.4
Uruguay	37.1	40.1	662		3,636	9,200	435	
Venezuela	16.6	26.6	1,063	1,337	5,396	11,300	1,073	62.5
Guianas	4.5		123		1,132		140	15.5
Costa Rica	54.1	77.4	228	355	4,140		576	34.5
El Salvador	148.8	376.8	269	361	8,100		654	38.5
Guatemala	77.2	112.2	274	307	11,290	16,300	1,174	33.6
Honduras	29.6	56.5	142	165	9,900	26,000	626	23.2
British Honduras	9.4		29		1,750		123	53.7
Nicaragua	19.6	33.6	209	233	4,840	17,300	352	40.9
Panama	24.2	45.4	100	174	6,780	13,300	193	41.5
Panama Canal Zone Caribbean Islands								31.9
Mexico	36.2	59.9	6,020	7,595	4,530	8,700	13,671	50.7
Cuba	136.9	176.4	690		8,145		799	53.0
Dom. Republic	123.9	200.7	272	315	8,420	18,000	624	30.1
Haiti	284.7	427.2	442	464	5,380	12,400	920	
Puerto Rico	685.0		369	430	5,800	8,700	465	44.2

Source: Vatican Atlas, Vienna, Anthropos Verlag, 1967

LEONARD KOVIT
Virginia Commonwealth University

LABOR IS HARD WORK:

Notes on the Social Organization of Childbirth

Sociological studies on childbearing and childbirth have mainly focused their attention on the demonstration of quantitatively significant relationships between medically defined phenomena and social characteristics of patients.¹ With few exceptions,² researchers have ignored the social setting and the personnel within that setting which have a direct bearing on the reproductive process. When this rather frequent biological activity occurs within the confines of a hospital, it comes to involve the clinical and social activities of numerous hospital personnel

ranging from ward clerks and secretaries to gynecologists and obstetricians. "Having a baby," no matter how biologically simple or complex, entails a phlethera of occupational and ritual specialists engaged in a concerted social activity involving numerous types of interaction, perspectives, and levels of social organization.

This report is an initial attempt at locating and describing some of the ways in which childbirth is "socially patterned". This refers to the activities of hospital staffs as they engage in their everyday practices of diagnosing, predicting, managing, controlling, and terminating pregnancy in accord with formal and informal rules, hospital social structure, technical medical knowledge, and common sense knowledge of patients and patients' problems.

Numerous studies have shown that statistically significant relationships exist between pathologies of pregnancy and childbirth, pregnancy and birth events and such social characteristics of patients as social class, race, parity and marital status.³ One can generally conclude from these studies that indeed certain interpretable relationships do

¹ For a concise review of the sociological literature on childbearing and childbirth see: R. Illsley, *The sociological study of reproduction & its outcome, Childbearing: Its Social & Psychological Aspects*, eds. S. Richardson & A. Guttmacher (New York: Williams & Wilkins, 1967) 75-142.

² For discussion of certain effects of the hospital setting on the childbearing process see the following: J. Emerson, *Behavior in public places: sustaining definitions of reality in gynecological examinations, Recent Sociology Number Two*, ed. A. Dretzel, (New York: Macmillan, 1970) 74-97; W. Rosengren & S. Devault, *The sociology of time & space in an obstetrical hospital, The Hospital In Modern Society*, ed. E. Freidson (New York: Free Press, 1963) 266-92; J. Henslin & M. Briggs, *Dramaturgical desexualization: the sociology of vaginal examinations, Studies in the Sociology of Sex*, ed. J. Henslin (New York: Appleton-Century-Crofts, 1971) 243-72; P. Rains *Becoming An Unwed Mother* (Chicago: Aldine, 1971).

³ For an extensive bibliography of this literature see Richardson & Guttmacher (1967).

exist between these phenomena. In fact the nature and direction of the relationships are what one would expect given previous etiological studies of socially related disease categories (e.g., higher socio-economic groups have lower frequencies of pathology than lower socio-economic groups).

Two assumptions underlie many of these studies of socio-medical relationships. The first assumption is that biological events are "objective facts." The second is that medical practitioners administer treatment on the basis of: (a) these "objective facts," (b) perception of the same social characteristics of patients as are perceived by sociologists, and (c) objective legal and medical constraints.

Several researchers have suggested that we treat (i.e., describe and analyze) biological events, biological states and medical diagnoses not as "facts," but as negotiated realities.⁴ In making these suggestions they assert two things. First, in the social world, medical diagnoses are negotiated verdicts which are not the result of the mere matching of patients symptoms to technical medical knowledge of disease related symptoms. Diagnoses are arrived at by the structured, and in some instances the legally mandated, process of "consultation." Each physician then renders his opinion public, whereupon the participants negotiate the determination of the patient's problem (i.e., they decide on which disease or pathological label to attach to the patient's problem), and their tentative future course of action (i.e., the treatment). Biological "facts", medical diagnoses, and the eventual treatment based on the decided nature of the "facts" are the result of discovery, recognition, investigation, labeling, consultation, and assessment which are in themselves not medical processes but social activities requiring the coordinated action of various specialists engaged in a concerted social activity.

Second, some researchers have asserted that in

order to understand how medical decisions (or for that matter any organizational decision) come to be made and carried out, the practitioners' perspectives and the nature of his social world must be investigated. In so doing we must not assume that their decisions are based on or influenced by the same social features we as sociologists perceive.⁵

In order to determine how various features of the childbearing process come to be socially constructed, *in situ* observations and unstructured interviews were conducted in the labor and delivery rooms of three hospitals over a period of one year. Two of the hospitals were in the South and the other was in New England. In addition, the hospitals were of different types. The hospital we shall refer to as "Center" is a teaching hospital serving most of the medical needs of the community. Its patients were seen primarily by residents (i.e., the majority of obstetrical patients did not have their own private obstetrician but were seen by whoever was "on call" when they arrived). The hospital we shall refer to as "County", was also a general hospital but its patients were seen solely by private practitioners (i.e., the patients were referred to the hospital by their own doctors and treated there by him or others he so designated). The third hospital was a women's hospital in which were treated only medical problems specific to females, both gynecological and obstetrical. Its patients were both staff patients (i.e., seen by residents) and private patients. This hospital shall be referred to as "Women's". (Unless otherwise stated, references to this hospital will refer solely to the public sector of the hospital — the residents and their patients—since the researcher was denied permission to work with or observe private doctors at work.)

In terms of the collection of data, the researcher (a male) was physically present in the labor rooms, delivery and operating rooms, nurses stations and lounges in each of the three hospitals. With the exception of the

⁴ For a discussion of the negotiation process see: E. Freidson, *The Profession of Medicine* (New York: Dodd & Mead, 1970); J. Roth, *Timetables* (Indianapolis: Bobbs-Merrill, 1963).

⁵ For the theoretical reasons for such a stance see E. Bittner, The concept of organization, *Social Research* 32 (1965) 239-55.

limitations placed on the researcher at Women's, he was free to roam, observe and question staff throughout the care process. However, the discussion will be limited to the last few hours of childbirth, ignoring, for the present, the pre- and post-natal period.

INSTITUTIONAL FRAMEWORKS & CLINICAL PRACTICES

The management of childbearing and childbirth (as well as other medical problems treated in hospitals) are in part governed by practical work considerations such as spacial and temporal limitations, kind and amount of ancillary personnel, hospital rules, available medical technologies, legal rules specific to the procedures in question or to the state in which the hospital is located, competing facilities, and etc. Since different types of hospitals (e.g., public, private, women's) are constrained to some degree by different work considerations, the management of childbearing and childbirth differs as regards these constraints.

For example, the decision to "pit a patient" (i.e., augment or induce labor by the use of the drug Pitocine) is clearly based on organizational rather than medical criteria. (It is not being suggested that doctors ignore medical features in the administration of drugs, but rather than non-medical features of the situation have become built into the drug giving process. These features are not "taken account of" consciously as decisions are made on an individual basis, but rather take the form of a "taken for granted" routine within each setting.) At County, a private physician waiting for his only "girl" to deliver at three A.M. will be faced with a different set of decisional criteria than a resident at Center on his nightly rotation with five "girls in the house", and from a resident at Women's with fifteen patients, although all the patients may "present" identical medical problems. In all instances the decision will be based on the "usual ways things are done". The staff have adapted to practical work considerations—such as number of patients, available help, available technology, etc. — by the development of routine procedures for given

case types, which become taken for granted and non-problematic as long as the case is not "unusual" or "interesting". These usual methods differ in each hospital. At County, a drug will be administered to the patient (i.e., the patient will be "pitted") in such a way that the physician can legitimately and legally return to sleep, to his home, to his office, or to other work later to be called by the nurse. This is possible because the use of this form of the drug does not require his presence. (County was the only one of the three hospitals that used the pill form of the drug. Had the physicians at County used the intravenous form of the drug, they would not have been able to leave the hospital after administering it. This is the case, because the "standard of care" as conceived legally, was the practice employed at a larger hospital near County which required that when I.V. pit was used the doctor remain at hand. In order to avoid the necessity of being constantly present while still maintaining the appropriate standard of care, the physicians used the pill form of the drug since no standard of care had been established as no one in the area was using this form except at County.) At Center the use of pit would require that the resident remain available to watch for irregularities. At Women's a variety of drugs might be given but the nurse would stay with the patient while residents and students performed other tasks.

Furthermore, individuals within each hospital have developed reputations regarding the manner in which and their willingness to perform certain tasks. For instance, there are doctors who are perceived by nurses and other staff members as not liking to perform deliveries. This belief being based on work experience at the doctor's side. Doctors could regulate drug flow, administration of analgesics, or other factors so that the patient would probably not deliver before he left his shift. Similarly there were those who wished to get the thing over with quickly and somehow managed to accomplish speedy deliveries. There were also physicians who had no inclination either way, perhaps the majority of them, because of their bedside manner or adherence to standard procedures were able to routinely effect the labor process.

There are other ways of shortening the length of labor, for example, amniotomies and caesarian sections. Here too, doctors develop reputations among their colleagues regarding their willingness to employ various procedures under certain circumstances, especially regarding sections. Some doctors are more easily swayed (by their peers or by their patient's "presentation") to perform sections. They perceive certain medical situations as being "indications" for a section which others might hesitate on. When a physician needs a consultation in order to perform a section or an abortion he takes into account other doctors' reputations before asking them to cosign a consent form, as their attitudes toward a case may be different. Once a consultation is requested it cannot be discounted. Whereas some obstetricians may be perceived as being too willing to perform sections by their fellow obstetricians, pediatricians are often heard complaining that obstetricians don't perform enough sections or when they do, it is not early enough from their perspective. Clearly it appears that the length of labor a patient experiences is, in addition to biological determinates, effected by what type of hospital she chooses to have her baby in, since different hospitals have different rules and routines which impinge upon the labor process.

Several factors make it unfeasible to test the above remarks. First, labor is not a standardized unit. It has boundaries, yet no two labors have identical biological durations, making objective statistical comparisons difficult. Second, hospital records are inordinately inaccurate. Some of this inaccuracy is accidental, while some of it is built into the record keeping process. Records on blood loss is a good example of the inappropriateness of hospital kept statistics for sociological research. After a delivery, a record is made of the volume of blood lost by the patient, or put more accurately, the "patient's blood loss" (since it is not always the patient who is doing the losing). Examination of hospital records indicates that: (1) the range of blood loss is not wide (i.e., it appears that different people lose about the same amount of blood in similar medical situations), and (2) the range of

blood loss is narrower when the figures are grouped by the physicians who performed the deliveries (indicating that certain doctors produce lower or higher blood losses—in fact or in fancy). Furthermore, there are hospital rules which have the effect of creating work for doctors when these figures exceed the amount defined as a hemorrhage. In fact, at one hospital this figure was lower than that found by medical researchers to be the average amount of blood loss for an uncomplicated delivery. This meant that to record an accurate blood loss figure was by definition stating that the patient had a hemorrhage, which might not be the case. In addition, blood loss is rather difficult to accurately measure, since so much of it is soaked up by surgical drapes and gowns, spilled on the floor, and etc. An additional problem is that certain doctors look at these figures as a matter of their own competence—high blood loss somehow indicating their error—so that certain doctors record exceeding low blood loss figures.

These various record keeping constraints and features apply to the data gathered on the length of labor as well. The most troublesome feature, as regards the sociological meaningfulness of the collected statistical data, is that doctors use length of labor to make decisions about length of labor. There are three stages of labor and accordingly a time duration for each. A long first stage would be used as data upon which to make a decision about the medically acceptable length of the second and third stages and what should be done about these. In order to understand the data about "labor times" one must take into account hospital rules and routines for dealing with certain medical problems. For instance, a patient in labor with a ruptured membrane is allowed to remain in that state for different lengths of time depending on which hospital she was in—ranging in this particular instance from several hours to twenty-four hours to several weeks. Data on the first stage (time between onset of labor to full dilation and effacement of cervix) reflects among other things the patient's memory of when labor started, whether this is a first labor or not, and etc. Data on the second stage (the time between

full dilation and effacement to the delivery of the baby) reflects not only biological happenings but also hospital routines regarding acceptable lengths of labor, amount of drugs given, whether the patient has a private nurse to aid her progress through labor, how crowded the delivery rooms are at the present time, whether the doctor has reached the hospital, and etc. Data on the third stage (the time between the delivery of the baby and the expulsion of the placenta) is not effected by many extra-medical factors, although it is effected by the doctor's attitude toward manual extraction of placenta versus spontaneous expulsion.

SOCIAL CATEGORIES & CLINICAL PRACTICES

For years, medical sociologists have been investigating the relationship between the medical treatment accorded a patient and the social categories into which the patient can be classified. For the most part, they have been concerned with standard sociological categories (e.g., race, social class, education, marital status, etc) and a limited group of medical categories (i.e., those involving pathology and disease, ignoring until recently such biological phenomena as bio-chemical processes).

Given previous studies one would expect that similar relationships could be found pertaining to the childbearing and childbirth processes. Documenting these relationships would be meaningless without an accompanied search for and analysis of the ways in which these variables come to be related within the hospital setting. Furthermore, standard sociological categories may not necessarily be the ones operating within the hospital setting. Categories other than race, class and education were found in this study to be both operant and relevant to the ongoing activities of the delivery team. That is, these categories were found to be part of the practitioner's perspective and in such capacity ordered his social world and made his future plans for action intelligible to others within the hospital.

Some of the most frequently used categories are "mothers," "fetus," "still-birth," "difficult labor," "normal delivery," "premium babies," "girls," "interesting cases," "toads and turkeys," and etc. These categories are "real" to the delivery team and they come to have "real" clinical consequences. However, unlike certain scientific categories these are flexible—the rules for the application being variable depending on the context of their use and the referent to which they are presently referring.

Sometimes during the last trimester of pregnancy the patient is admitted to the labor floor. Usually, but not always, this corresponds to the patient being in the first stages of labor. Claims of "being in labor" are open to interpretation by hospital personnel. A patient arrives at the labor ward either due to her self diagnosis of "being in labor," her self diagnosis in conjunction with a phone call to her physician or an office visit wherein the physician felt she was "ready" and ought to be admitted. In the first two instances the claims may not be supported by actual biological activity. Frequently patients who arrive on the labor floor on the basis of self diagnosis are sent home after a short while of not "progressing." Usually these are "primips" (patients in their first pregnancy) who are not aware of the theoretical signs of labor but due to lack of personal experience cannot correctly diagnose their own condition. This early arrival may also be the result in some instances of the patient fearing that she might deliver in some untoward situation — like a taxi cab. This concern over the location of the delivery is not limited to patients and their close relatives. Several cases were seen where ward clerks and admitting room personnel rushed patients to the labor floor with accompanying attempts at arousing hurried activity on the part of the labor room personnel. In several of these instances the patients turned out not to be in labor at all. In one case the patient was not even pregnant, in fact she was incapable of pregnancy since her uterus had been removed several years prior. The patient it was later discovered was drunk. The clerks hurried activity being based solely on the patient's claim with no attempt on the clerk's part to verify these claims.

There is another side of the coin. "Multips" often exhibit a reverse situation. They really might deliver quickly and unexpectedly. The only indicator of this being the patient's past history, which is not always readily available. In order to avoid being faced with an unexpected delivery, the first requests for information from a patient are whether she is a multip or a primip. When staff exchange information on patients they usually report as their very first remark the patients' gravida and parity. They frequently use these as informal means of identification instead of the patient's name (e.g., "Whatever happened to that 6-5-5?"). (Gravids is the number of pregnancies and parity the number of deliveries. A patient who has been pregnant twice but who lost one baby prior to delivery would be referred to as a "gravida 2 para 1". When employing a three-digit system, the last digit refers to the number of live children the patient now has. A patient who has had four pregnancies, three deliveries, and two live children would be a "para 4-3-2".)

Once the decision is made to admit a patient, referred to by the staff as "keeping them", the first task performed on the patient is the "prep" (short for preparation—which entails a shave and an enema). The sociological significance of preps in these hospitals involves the fact that there are several kinds and these are differentially allocated on the basis of social rather than medical lines. All the public patients regardless of which hospital they were in, received a full prep (i.e., a full shave of the perineum area) while most private patients were given a "mini" or "partial prep". Physicians catering to the private patients felt that partial preps were "kinder", would be preferred by patients were they given a choice (which they weren't) and in any event were just as septic. Physicians who gave full preps claimed that they were better septic procedure and in any event were the "routine way around here". Although this may not seem to be of crucial significance, it represents in miniature the attitudes and relationships that exist between type of patient and the type of doctor that treats them.

Two additional examples will further clarify

how categories effect clinical practice. The first regards "products of the womb". Depending on the label assigned such "products" (e.g., fetus, stillbirth, baby) practices will vary. For instance, the product of an abortion having the same physical characteristics as the product of a delivery (say 25 cm., 300 grams, and 10 week gestation) will be handled differently, although biologically they are of the same type. The former will always be handled in terms of disposal procedures while the latter may at times be sent to the morgue for proper burial.

The second example regards the problematic nature of categories and its relation to clinical practice. Calling a patient a "multip" implies doing certain procedures in certain ways (e.g., since she is likely to deliver more quickly than a primigravida she is handled with more urgency and caution). There are at least two instances in which the assignment of this category to a patient is problematic. The first is a woman having her second child but her first child in wedlock (occasionally referred to as a "social primigravida"). The other is a patient in her second pregnancy where the first pregnancy terminated prior to labor or delivery. Babies being "carried" by such a patient are usually called "premium babies". In these instances the staff decide whether to administer the practices appropriate to "multips" or "primips" and in so doing alter the practices to fit the categories or alter the categories to fit the practices.

COORDINATING ORGANIZATIONAL & BIOLOGICAL CLOCKS

Biological events have their own temporal dimensions (e.g., time of onset, duration, sequences, etc.) as is obvious in the cast of childbearing. Similarly, organizations have their own temporal features (e.g., shifts, rotations, schedules, etc.) One problem common to the staffs of many organizations is coordinating the organization's temporal system with the temporal dimensions of certain biological states of its clients and its own staff.

In coordinating these two time clocks the staff have to take account of four factors in order to anticipate their own future activities. These factors are: the volume of clients expected, expected time of arrival, expected length of stay, and the probably diversity of clients' needs (i.e., patients' problems).

Unlike many other client-centered organizations, labor and delivery wards can be characterized as a feast or famine situation. Date of delivery is relatively unplannable. How many patients will show up "in labor" on a given day is unknown and unplannable. Therefore labor-delivery wards are usually equipped for heavy volume even when none can logically be anticipated. The staff are aware of this problem and see their next day's work as being one in which they will be really busy or where no one will show up. They refer to this as "feast or famine", and hope the next day will be neither.

In order to have some notion of expected volume the nurses stations have records of presently pregnant patients who will deliver in this hospital in the near future. The prominent feature of this file being the patient's "CDC" or "EDC". The "Calculated or Expected Date of Confinement" is one way of anticipating patients' arrivals. It also provides the patient with the answer to the question, "When is it due?". However, CDC is not a fixed date; the actual date may differ depending on who is calculating it and who is making the inquiry regarding this CDC. When they diverge it is the result of a calculated plan with certain intended consequences.

CDC's reflect several different types of counting procedures. In the very extreme it represents a theoretical data. That is, physicians take as base the number of days or weeks at which a theoretical baby is assumed to be "ripe for delivery". They then schedule the patient for delivery on that date, regardless of the stage of labor. (Usually labor is then induced by amniotomy and pit.) This way of calculating due dates would make expected volume easily calculated if everyone were to deliver this way. Since few physicians deliver babies "on schedule", the problem of unknown expected volume is not alleviated. A

second method of calculating CDC, and the one most often used by doctors, is to compare a patient's present status (how far along she is in pregnancy in terms of time and fundus size) with the theoretical length of labor and come up with a date. Since the theoretical length of labor is not referred to as a specific number of days, (there being several weeks latitude) they can also take into account the patient's previous behavior (whether she has a history of long or short pregnancy). A third method used by several doctors is to calculate CDC as above but add from one to two weeks to that date. The purpose of this is to keep the patient from arriving in the hospital before she is really due and to make the patients happy. Patients whose CDC has passed and they still have not delivered get anxious, which is undesirable from a medical stand point. Physicians feel patients are somehow happier when they deliver on time — seeing this as a good sign of their babies' condition and their doctor's prowess.

Another factor which organizations have to account for is "length of stay". At most of the obstetric wards today the stay on post partum floors is roughly three days. Several years ago the length of stay lasted up to several weeks. This is due to a change in the conception of time required to "recover", as opposed to a change in the "length of stay" unit. The "length of stay" unit has remained the same — patients stay until they are recovered. The change is that "recovery" has been redefined as taking less time.

THE SOCIAL CONSTRUCTION OF CLINICAL PRACTICE

Clinical practices are events whose construction is problematic, and can therefore be viewed and analyzed in terms of their production. The events whose production is problematic and which will be discussed here are: the diagnosis of pregnancy, the type of delivery, the make up of the delivery team, and the sociological stages of the delivery.

"Diagnosis of pregnancy" can be looked upon as having certain features upon which it

depends. That is to say this event, as well as the others will be produced differently depending on the situational features, the contextual features, the biological facts and the individuals concerned. The "diagnosis of pregnancy" depends on at least three factors::

1. The patient's construction of her medical biography. When accepted standards of biological reconstruction are not used, the relevance of the reconstruction is put into question, as was the case when a patient reported the amount of menstrual flow in terms of "bed sheets" instead of "sanitary pads".

2. The physician's trust in the patient's construction and his eventual reconstruction of her biography. For example, one patient was able to construct a convincing history concordant with pregnancy, but the physician could not place trust in her report because her hospital records indicated a history of pseudocyesis (false pregnancy).

3. The physician's ability to hear, feel and recognize certain signs. This is illustrated in doctors' conversations when they compare their abilities to detect certain signs. The ability to hear fetal heart rate at an early date (of about sixteen weeks gestation) is such a faculty.

Other productions do not depend as much on the doctor-patient relationship as on the structure of the medical profession itself.⁶ For instance the production of "delivery" as a certain type (spontaneous, low forceps, forcep rotation, section, etc.) is not entirely a function of patients' needs but is also influenced by the position of the doctor in the hospital structure, the frequency with which he has previously performed this practice and his attitudes toward this procedure. One merely has to observe the frequency of competition among residents to

perform certain procedures,⁷ and the not too unusual occurrence of one staff member deriding his fellow practitioner for the unnecessary frequency of certain procedures he undertakes, in order to witness the effect of social structure on clinical practice.

Which physician gets a specific delivery is related to a host of factors. There are four types of activities which result in a certain person performing a delivery when that individual does not have primary responsibility for that patient (e.g., a resident allowing, supervising or instructing a student in performing one of the resident's deliveries, or a private man letting a resident perform a complicated or an unusual task on one of his patients). Medical practitioners refer to the above action as "dumping", "giving away" and "training". They can be presented schematically as:

	Person responsible for the medical task to be performed	Other person who actually gets to perform the task
"Dumping"	—	—
"Giving Away"	+	+
"Training"		
Type 1	+	—
Type 2	—	+

The signs indicate the persons negative or positive attitude about or desire to perform this task.

In any situation where people are being trained those doing the training will let others (i.e., those being trained) perform certain tasks for which they themselves are responsible. Patients are almost always unaware of the process by which a given physician comes to be doing work on her body. One way in which a physician (resident, student or in some cases a private physician) arrives at a task is by the process of "dumping". By this term doctors are referring to a situation wherein both the person responsible for the task (i.e., the person being paid to perform the task, or the person whose

⁶ For instance, Emerson's description of how gynecological exams are produced. Henslin's work also gives an example of how this process works.

⁷ For numerical counts on the procedures performed by residents in different periods of training see: N. Newton, A profile of residents in obstetrics & gynecology, *Obstetrics & Gynecology* 28 (1971) 163-69.

signature attests to his having performed it), and the person who actually performs the task (either as a result of a favor, a command or a request that for various reasons cannot be turned down) would rather not, given a choice, engage in this specific activity. This differs from "scut work" in that "dumping" is not descriptive of the task, but the process by which one arrives at the task. "Scut work" describes the nature of the actual task. They do not always go hand in hand but they can. There are other names used to describe "cases" as opposed to the way in which you arrive at them or the work you perform on them; some of these are: "Interesting cases," "Unusual cases," "Routine cases," and "Classic or textbook cases."

On the other hand, when a person responsible for the task gives or lets another person perform the task when they both would like to engage in that medical procedure, this is referred to as "giving away" or "a give away." Although dumping and giving away are sometimes conceived of as part of the training process, from the perspective of those doing the training, they are not really of the same type. Dumping or giving away imply future activities on the part of those performing the task (i.e., responsibilities to reciprocate in the case of giving away, and grudges with their implied future courses of action as in the case of dumping). A person being trained is not conceived as engaging in a reciprocal bargaining process where present tasks imply future actions vis a vis the trainer.

It was found at Women's hospital that in order to receive help on minor cases the person requesting the aid had to be reputed to "give away" cases. In other words you (usually) had to "give away" some interesting cases in order to get help on the dull or routine ones. Indeed physicians developed reputations among residents, students and other staff for (or for not) "giving away" cases. Since it is deemed a necessary part of the training process to let those lower in status perform progressively more complex tasks, the "give away" system was positively valued. Those who did not adhere to the system but who gave lip service to it were quickly discovered by those lower in status,

and the news about specific cases spread quickly among the relevant staff.

One method of appearing as if to adhere to the system when in reality not doing so (keeping in mind that the task is positively valued by all) is to claim that a given task is a "give away" when in reality it is "training" (of the type the writer calls type 2) or even worse, an attempt to convey the impression that a "dump" is a "give away". (Physicians do not talk about "type of training", merely "training"—the division is being imposed here to make logical distinctions.) Another tactic used is to claim the case is a "give away" but when it comes down to the actual set of tasks only certain aspects of the task are performed by the lower status person and usually those not positively valued but a necessary part of the task. (For instance, a physician may tell one of the residents that he can perform a certain operation, but, when in the operating room, only let him make the final closure instead of the whole procedure.) This task assignment process is a crucial part of the delivery room scene, in that who delivers effects the type of delivery performed. (The above typology is no doubt applicable to training situations other than those which occur in hospitals, especially where tasks are distributed by other than those who perform them.)

Of course other factors are involved in the decision to assign or let a specific person do a specific medical task (e.g., a delivery, section, etc.). The nature of the task is taken into account as well as the competence of those being considered for the performance. In addition, it depends on who is "on" ("on call"), who is available, and sometimes who the patient is.

Another structural feature has an effect on who got to do what. Residents at both Women's and Center are allowed to do only certain procedures, regardless of their competence, during certain periods of their training. The number of types of procedures regularly increase as one advances through the program. The more advanced one becomes the more one is allowed to do — a seemingly rational system. However, consider the collary.

The more one is allowed to do the more he will do. The concept of "trying" is a case in point. Doctors are rarely heard using the term "practice" in reference to a specific procedure (although they use it often when referring to a doctor's "business" — his "practice"). But they often say, especially when entering a phase of training which would allow them to perform a task, "I'd like to try this procedure." At the beginning of a period in which they are allowed to use certain techniques (e.g., forcep deliveries), or perform certain procedures (e.g., sections) they "try" them often and some venture to suggest this is more often than warranted, given the medical needs of the patient population. (Pediatricians are often heard complaining that obstetricians perform too many forcep deliveries.)

The delivery room is the setting wherein patients and patients' problems come into extended contact with doctors and doctors' problems, and with formal and informal hospital rules and routines in order to create a delivery. Except in unusual circumstances, deliveries are composed of three (social) stages which can be labelled: "Patient introduction," "Baby announcement," and "I'm done-congratulations". These labels refer to segments of the dialogue which were found to be operant regardless of the particular participants involved.

When a patient is wheeled into the delivery room she is prepared socially as well as medically. This stage, referred to here as "Patient Introduction," is marked by statements which refer to the patients condition and the nature of her present activities. These are always followed by qualifying remarks. Patients are invariably told, regardless of their actual condition, that they are "doing fine" and that "they will be all right". Hopefully, if patients follow the staffs commands to "push", "breath," "relax," and "pant" they will in fact be all right. Remarks are also made about labor and delivery in the abstract such as "labor is hard work" or "this is the hard stage". These too are followed by qualifying remarks such as "it won't be long now". It is during this stage of delivery that the difference between private and public patients becomes obvious. A

resident delivering a patient who he has never seen before that day has much less to say to that patient than a private patient's doctor who is acquainted with his patient over a long period of time. In the first instance talk is limited to the kind of remarks quoted above. In the delivery of a private patient the doctor can draw on a wealth of information about the patient, her family and her problems, in order to create conversation which includes the above remarks but adds more personal touches (e.g., your husband wants a boy, doesn't he?" or "I'll bet your mother will be proud of this baby," etc.).

In this stage of delivery the patient is usually the one doing most of the work (e.g., pushing, breathing, etc.) while the staff stand by giving orders, watching her progress and waiting. The talk used to illicit certain types of responses from the patient become an important part of the delivery process. Although this talk is routinized, certain doctors are better at it than others, thereby impressing patients to different degrees. (Obstetricians believe that from the patients perspective their social skills are just as important, if not more so, than their medical skills.) An interesting non-verbal aspect of this stage of the delivery is how the patient is secured to the delivery table. At Women's, patients were not strapped down to the delivery table unless they "present" unusual manageability problems. At Center, all patients, regardless of their behavior, were strapped to the table (e.g., their hands were secured to the table by means of large leather straps.)

The second stage of delivery can be labelled "Announcement of birth". As the baby's head emerges, the doctors tries to get some impression as to the baby's condition while he also sucks mucus out of the baby's mouth. This is done so that the baby's state can be quickly determined and breathing readily induced. If a problem exists, preparations can be made to handle this before the announcement of birth is made (e.g., the patient can be given more anesthesia). When the baby's body is fully delivered the doctor announces, "It's a boy." This is repeated by others in the room until it is certain that

everyone present has heard the news. Once it is certain that everyone knows the baby's sex (the mother being told several times) an announcement is made that it is a "fine boy" or "He's got all his parts" or "He's a big one". At County and Center babies were weighed while still in the delivery room and an announcement made of its weight. In hundreds of deliveries witnessed, in not one case when a live viable baby was delivered was the announcement of sex or weight made only once. It was always repeated several times, by various people, as if to impress on the participants and the patient the result of their (her) work.

The final stage of the delivery dialogue is marked by telling the patient that she "did a good job", or "good work", Or "that's a beautiful eight-pound boy, congratulations" or simply "I'm done —congratulations". These statements have little to do with the way in which the patient actually behaved during delivery or the looks of the baby. Patients who acted atrociously from the staff's perspective were told the same thing. Babies called cute in the delivery room in the presence of the mother were often called other things when the mother was out of

earshot. These statements are used to keep or make the patient "happy" with her performance and her production. After all, as students and residents often remark when asked why they like to work in the obstetrics department — "It's a happy place".

CONCLUSION

This paper has attempted to show the ways in which certain of the biological events of childbearing and childbirth come to be differentially, socially patterned within the obstetric wards of three hospitals. The focus being on the social setting of the wards and delivery rooms and the staff working there rather than factors outside the hospital, other people relevant to the patient and the patients themselves. Although no attempt was made to describe or even acknowledge all of the possible sociological features of this situation several topics deemed to be significant were briefly described — how physicians divide up the patient population, how a certain physician comes to perform a task on a given patient, some of the constraints which they face in performing these tasks, and some of the features of the tasks which they perform.

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CHILDBIRTH: A Family Affair

The media today emphasize the fact that the American family is in trouble. A common focal point of discussion is the lack of effective communication between parents and children. This writer believes the root of the problem can be traced to the early days, weeks, months and years of the child's development. The traditional autocratic role of the husband in the American family has undergone marked change. English & Foster in *Fathers are Parents Too* write:

In stepping down as a dictator he has abdicated to a pretender.

Those who support this viewpoint feel the husband is so busy earning a living that his children grow up "orphans" so far as any upbringing they had from him is concerned. Books and articles on family relations too often seem to imply that a child's only parent is the mother. One of the few areas where the father is given his just dues in our culture is in the advertisements where he is represented as the good provider. He does have his moments on Fathers Day!

Opponents of the current women's liberation movement claim it has contributed to an imbalance in family life. Some critics go so far as to say it has tended psychologically to emasculate man and that many women place

the prestige value of a career above the traditional emotional satisfactions supposedly provided by homemaking and motherhood.

This apparent confusion in roles carries over in the father's responsibilities in the personality development of his children. Fathers need to gain more insight into the needs and developmental requirements of their offspring. English & Foster support the foregoing when they write:

In a society where, to a large degree, men rule, make the laws and control values, it seems illogical that they do not take a greater interest in the 'products' of their bodies — their offspring — than in the products of their factories and assembly lines. Having made such tremendous contributions to the arts and sciences, what could they not accomplish if they turned their attention to producing better children?

Marriage is an institution peculiar to man. Webster's *Seventh New Collegiate Dictionary* defines marriage as "the mutual relation of husband and wife." However, the traditional approach to childbirth in our society has not been a mutual experience. Involvement of the husband in the pregnancy and the birth process will provide a "natural" for

establishing the father-child communication bond. A married couple has to face all kinds of experiences together, both good and bad, so why shouldn't they share this experience? Why should they be torn apart during a crisis like childbearing—surely one of the most important moments in their married life? Hospitals have been more procedure than person oriented in their handling of childbirth. In other words, the procedure focused on satisfying the physical needs of the mother and baby. An exception to the rule is the Porter Memorial Hospital in Denver, Colorado, which reported in 1965 that over 4,000 husbands had been present with their wives in the delivery room at the moment of birth over an eleven year period.

One of the pioneers in promoting an understanding of childbirth was Dr. Grantly Dick-Read. He is best remembered for his *Childbirth Without Fear*. In the preface he comments on the role of men in childbirth:

But still we as men are not near enough the nature of women. We neither feel the magnitude of our responsibility nor plumb the depths of our compassion. We are frustrated by the yearning of a laboring woman for companionship we cannot give.

It is doubtful that any man can appreciate the meaning of "labor" in childbirth unless he witnesses the birth of a child. This experience makes the husband more aware of the wife's need for assistance when she and the baby come home from the hospital. If the husband is not in a position to give her the necessary assistance, he will be prone to see to it that outside help is made available.

In commenting on the role of the father in *Childbirth Without Pain*, Dr. Pierre Vellay writes:

During pregnancy and preparation for confinement, the husband is an effective manager. He is, moreover, a link between his wife and the obstetrical team. This intimate collaboration has a corollary; it reinforces the bonds between the couple and their future child. The attention of

the husband, his understanding, his kindness enormously facilitate the pregnancy of his wife. He says further, "I have not seen any husbands feel uncomfortable but I have seen many wipe away tears of emotion at the birth of their child."

In many countries it was a crime for men to attend women in labor until the Sixteenth Century. The more civilized the people, the more the pain of labor seems to be dramatized. The book of Genesis appears to treat childbirth as a sin. In the third chapter, sixteenth verse: "The Lord God said to Eve: 'I will greatly multiply thy sorrow and thy conception; in sorrow thou shalt bring forth children.' As late as the middle of the Nineteenth Century the foregoing was used as justification for opposition to any active relief of the sufferings of women in labor. In April 1853, John Snow gave Queen Victoria anesthetic when her son Prince Leopold was born. Simpson was sharply criticized by the church because he had no right "to rob God of the deep, earnest cries" of women in childbirth.

Dr. Dick-Read comments that "the prestige of a satellite in orbit about the earth is infinitely greater than the prestige of a revolutionary approach to the breeding of better human stock, or the founding of homes and family units of happy and contented people . . . schools, colleges, and universities do not include in their curriculum the supremely important subject of motherhood", In discussing a medicated vs. a "natural" (the term used in this paper refers to a situation in which the mother has been prepared for the experience through an education process) he quotes a noted gynecologist as saying, "It is better for us if they (Mothers-to-be) don't know anything about childbirth, and anyhow it is our job, not theirs."

A Christian woman's "fears of childbirth" are supported by the Prayer Book (there has been no substantial change in it since A.D. 1662) in which there is a special service known as "The Churching of Women" which is a thanksgiving after childbirth:

Oh, Almighty God, we give thee humble

thanks for that Thou has vouchsafed to deliver this woman, Thy servant, from the great pain and peril of childbirth.

Counteracting the Prayer Book and the Bible is not an easy task for present day advocates of education for childbirth.

In *Commonsense Childbirth*, Lester Dessez writes: Giving birth is the pinnacle of a woman's career — a time of love, wonder, and untold fulfillment. Yet for many thousands of American women, caught up in the routines of modern American medical practices, having a baby has become a frightening, humiliating, painful and sometimes deadly ordeal. She maintains that birth should be viewed as one of life's natural experiences, not a medical emergency.

In a good marriage, pregnancy should intensify a man's love for his wife. The importance of the husband's attitude toward and understanding of childbirth cannot be exaggerated. The wife's happiness during pregnancy and her approach to labor will be influenced by her husband's state of mind. The husband who assists his wife during the pregnancy and the childbirth can boast honestly, "We had a baby!"

Dr. Dick-Read writes: "The real joy of childbirth is most frequently experienced when husband and wife have mutual confidence, affection and understanding, and have worked together in preparation for the arrival of their baby. . .for pregnancy sets the course of women for the fulfillment of herself. . .she is no longer a woman in love only with a man, she is the mother of her man's child." Dr. Dick-Read believes that a high percentage of unnatural and difficult births are due to the husband's behavior toward his wife during pregnancy. The unprepared husband has no place at the birth of his child. The question is not, "Should a husband be present?" but, "Can this husband be of any service to his wife by being present at her confinement?" Studies indicate that the doctors themselves are the principle obstacle to allowing fathers in the delivery room. Dr. Alfred Tanz, professor of obstetrics

and gynecology at New York Medical College feels the least doctors can do is to give the fathers a choice.

John S. Miller, M.D., Chief of Obstetrics and Gynecology, French Hospital, San Francisco, California, says in the foreword to *Commonsense Childbirth*:

Women and their must be trained for childbirth, a fact now taken for granted and government sponsored in much of the Western world. Husbands must be restored to a position of dignity in this event by which they become a parent, no less than do their wives. It seems so obvious the habit of separating mother and baby at birth and for most of the next several days is almost criminally neglectful of the most fundamental needs of both. Hospital personnel have a tremendous responsibility to promote the sense of family as two people become three, rather than to replace this unit at every step of the way.

The pinnacle of kindness and understanding in marriage would be for a husband to coach his wife through labor in childbirth. Empathy is the key to the success of the coach in labor. It goes without saying that the success of the husband's coaching role dates back minimally to the onset of the pregnancy. For example, the understanding husband sees that his wife eats properly and gets plenty of rest; he "tolerates" her food cravings and her morning sickness. The husband compliments his wife on the "beauty" of her pregnancy; he gives up sexual intercourse but not demonstrative affection in the last trimester of pregnancy.

The husband needs to know when to take his wife to the hospital. Doctors differ on this but a rule of thumb is when contractions are strong enough to require labor breathing with each one, then it is time to go. Obviously arrangements would have been made ahead of time in most hospitals if the husband is to be with his wife in the labor room.

Some husbands develop guilt feelings about getting their wives pregnant. In such cases a husband may be over-solicitous for his wife's

welfare. Such concern may not be as altruistic as we might want to believe. A case study cited in *Fathers Are Parents Too* illustrates that such behavior could be based on guilt feelings stemming from early sex training. The husband's father had constantly warned him as an adolescent about getting a girl "in trouble" if he did not control his sex urges. He developed the attitude that sex relations somehow do a woman great harm. Anxiety of this sort is not always dissolved with marriage.

Within the past fifteen year, St. Marys Hospital in Evansville, Indiana, has been doing an experiment in family-centered maternity care. Until 1956 the conventional maternity care program was employed in the hospital. Its design was patterned upon a respect for the natural qualities of the infant and the emotional as well as the physical security of the parents.

The role of the husband is essentially the same as discussed previously wherein the husband is assisting the wife during pregnancy, labor, and childbirth. Following delivery, the husband, wife and new baby go to a private cubicle of the maternity recovery room where they remain for several hours before being transferred to the post-partal division. The mother determines the extent of her care of the infant during the post-partal period. The father is invited to participate actively in the care of the child; he can come and go as he chooses throughout the day and evening. The infant is seen not merely as a physical creature but rather as a person with a needs pattern commencing at birth. The parents, through affection and mutual participation, contribute immediately to the child's emotional stability and subsequent character development.

Such a program is not only protective but it is also "constructively dynamic."

Women, too, can become overly dramatic about childbirth. Some view giving birth as doing society a "favor." Such women expect undivided attention during pregnancy and a life of ease after the baby is born. One woman reportedly told a psychiatrist with whom she

was discussing her husband's dissatisfaction with their marriage, "I gave him a son. What more does he want?"

Mothers should not look upon childbirth as a performance in which they must prove themselves. For example, such a woman might be determined to give birth without anesthetic no matter what the circumstances. Her major concern should be to have a healthy baby by the method that is best for her.

It is not unusual for a prospective father to have occasional feelings of jealousy toward a coming child. This is recognized by certain primitive societies in a prescribed ritual of antiquity known as the "couvade." Although forms of this ritual vary, the male typically takes to his bed at the time of childbirth and moans and groans, as if he were in labor, while waited on either his mother or other women of the tribe. He feigns great weakness, refrains from eating certain foods, and goes through a period of purification before resuming his ordinary activities. Writers differ in their interpretation of this ritual, but it does appear to be an attention-getting device of sorts.

Some men find it difficult to play second-fiddle during the wife's pregnancy. Many prospective fathers develop all sorts of new aches and pains without realizing that these are pleas for attention. The man who has morning sickness during his wife's pregnancy is by no means rare. Such action is probably based on a different premise for each individual. In some way the identification with the spouse is so strong that the husband manifests physiological reactions comparable to those of his pregnant wife.

The old cliché "We've never lost a father yet" still holds true. Thus there is still hope!

A father cannot start too early to forge the bond of friendship between himself and his child — this includes the "night shift" during infancy. The husband whose wife breastfeeds her baby may feel like the proverbial fifth wheel. However, closer examination will reveal that there is equal or even more activity

at the other end which needs systematic tending — diapering!! A truly loving father does not exclude any part of a child's activities from his responsibilities or relegate the care of the child entirely to the wife.

Although this paper has not focused on the involvement of siblings in the mother's pregnancy, it is of great importance. Both parents should help the siblings develop an understanding of the ongoing pregnancy process. Properly handled, the new arrival

should be an anticipated event shared by all members of the family.

The wife's attitude toward pregnancy is deeply rooted in the behavior of the husband. Education is the key to effecting a meaningful husband-wife and parent-child relationship. Curriculum offerings in our elementary and secondary schools, as well as in our colleges and universities, should reflect an awareness of this vital need.

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SOCIAL VALUES SUPPORTING PREGNANCY:

Dilemma for Population Control

Until recently, population experts were primarily concerned with the population explosion in underdeveloped nations (Enke 1968; Freedman 1963; Wrong 1961:113-15). Attention was focused upon the dysfunctions of excessive population increase for the economic development of a "less developed" nation. Nations too poor or too limited in resources to offset geometric population increases were the objects of advice, cajolery, and economic and technical aid from wealthy, relatively underpopulated industrial countries in the hope that the "population problem" could be solved. This emphasis upon the population explosion in the underdeveloped nations served to minimize concern with population-related problems in the industrialized nations.

In the past few years, however, the industrialized nations of the world—especially the United States—have become the object of scrutiny and concern by population experts. Paul Ehrlich (1968) has become the best

known proponent of American population control. Ehrlich has stressed the consequences of population increase, " , , , not just garbage in our environment, but overcrowded highways, burgeoning slums, deteriorating school systems, rising crime rates, riots, and other related problems." (1968:24-25). He has emphasized the interdependence of pollution and population:

Too many cars, too many factories, too much detergent, too much pesticide, multiplying contrails, inadequate sewage treatment plants, too little water, too much carbon dioxide—all can be traced easily to too many people (1968:66).

Perhaps more importantly, the author of *The Population Bomb* has emphasized the global impact of American birth limitation. Ehrlich sounded a clarion for attention to a new dimension of the population problem: population growth in the United States endangers the earth's resources (1968:133):

At the moment the United States uses well over half of all the raw materials consumed each year. Think of it. Less than 1/15th of the population of the world requires more than all the rest to maintain its inflated position. If present trends continue, in 20 years we will be

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much less than 1/15th of the population, and yet we may use some 80% of the resources consumed.

Providing food for starving people in the non-industrialized nations was directly linked to population control in the United States. In demographic terms, the population problem migrated to America.

As a result, population specialists are now making the same recommendations to Americans that they used to make only to citizens of underdeveloped countries. Voluntary birth limitation, vasectomies, sterilization, abortion, adoption, economic incentives, and economic penalties have been recommended to limit births in the United States (Ehrlich 1968:136-38). Organizations such as the Association for Voluntary Sterilization, and Zero Population Growth (ZPG) have increasingly dramatized the need to limit population growth. Thus, married couples are now advised to have no more than two children, thereby allowing the birth rate and death rate to approximate one another (Ehrlich 1968:175). Interestingly, Kingsley Davis had remarked only a few years earlier that zero population growth was not considered an acceptable planning goal for the nations of the world (1967:732). At present, however, massive information dissemination campaigns have sought to convince Americans, especially the young, that population control is essential for the future of America and the world.

Population control—the achievement of zero population growth—will be a major goal of concerned Americans in the 1970's. Whether or not one agrees with the ZPG philosophy, one must be cognizant of the numerous obstacles to the success of the movement. In this paper we would like to focus upon one major obstacle to the adoption of population control measures, the social values in American society that support pregnancy. (See Baumgartner, 1966:184-187 for a discussion of some cross-cultural similarities in ideology which oppose population control.)

ATTITUDES & BEHAVIOR

Implicit in the population crusade is the assumption that action—actually inaction—will follow education; that is, the realization of the population problems of America and the world is supposed to immediately result in a massive dedication to voluntary birth limitation. A considerable literature has emerged, however, which shows that attitudes and behavior are not always closely related, that behavioral change does not always follow attitudinal change. (DeFleur & Westie 1958; Deutscher 1966; LaPiere 1934). Several sociologists (Ehrlich 1969; Warner & DeFleur 1969) have noted that numerous variables may intervene between attitudes and behavior, so that changing attitudes does not insure changing behavior.

In regard to population control, Americans must not only believe in the necessity to limit population growth, but must also decide to forego any pregnancies after the birth of two children. We would argue that intellectual acceptance of the need for population control may not result in the avoidance of pregnancy because certain strong American values support and encourage pregnancy. There is no reason to presume that these values will become less salient after the birth of two children. As such, the American value structure is seen as the intervening variable between attitude change and behavior change—a variable which may result in the failure of the ZPG crusade, even if ZPG convinces Americans of the need for population control.

AMERICAN SOCIAL VALUES

Vander Zanden (1965:67-69) noted seven major American values: (1) rationality, (2) humanitarianism, (3) materialism, (4) success, (5) work and activity, (6) progress, and (7) democracy. It is our thesis that population limitation—the denial of pregnancy—is supported by rationality and humanitarianism, but is opposed by the values of materialism, success, work and activity, progress, and democracy in American society.

Rationality and humanitarianism are clearly the cornerstones of the argument for population control. As Vander Zanden (1965:68) noted, "Americans almost universally place faith in the rational approach of life We search for intellectual and scientific supports for our behavior." It is not surprising, therefore, that population experts have amassed impressive statistical data on birth and death rates, food production, and food consumption to rationally prove that population control is necessary. For example, Paul Ehrlich indicated that if the population of the world continued to double at its present rate, before the year 3000 there would be sixty million billion people on the face of the earth (1965:18). Drastic reduction of the birth rate is posed as the rational alternative to widespread starvation. These rational arguments have been reflected in the comments of some of the pregnant women with whom we have been conducting some exploratory interviews on the social meaning of pregnancy. Most of the women who plan to limit their childbearing to two children give two kinds of rational reasons: (1) financial inability to support more, and (2) information they have garnered from population experts on the effects of over-population. These rational reasons for limitation are often offered as counter-arguments to their emotional inclination to have "lots of children", or as one respondent noted, "at least four or five . . . except for the population thing."

Humanitarianism—the American tradition of benevolence, philanthropy and charity—is the second social value that supports the ZPG appeal. The humanitarian desire to avoid the starvation death of millions of humans is a vital factor in the population crusade. It is more than coincidental that the first chapter of *The Population Bomb* paints a picture of Dehli's population problems in emotionally tinged words (Ehrlich 1968:15):

The streets seemed alive with people. People eating, people washing, people sleeping. People visiting, arguing, and screaming. People thrusting their hands

through the taxi window, begging. People defecating and urinating. People clinging to buses. People herding animals. People, people, people, people.

VALUES SUPPORTING PREGNANCY

We are willing to grant, for the sake of keeping our presentation brief, that the rational-humanitarian appeal of zero population growth advocates will convince numerous Americans that the world's population explosion must be curtailed. We are willing to grant that numerous Americans will make the intellectual-emotional commitment to limiting their own families to two children. We are not willing to grant, however, that these attitude changes will ultimately result in voluntary birth limitation. Regardless of our personal values, our observations of American family life lead us to conclude that pregnancy is too important for American social structure for massive denials of pregnancy to occur.

To understand the importance of pregnancy for American family life, we must consider the alternative—childlessness and adoption. Childlessness appears to be an unacceptable alternative. Pohlman (1969:35-35) summarizes numerous studies which indicate that almost every American husband and wife desire to have children. Adoption, the alternative route to childrearing, is basically viewed in negative terms by Americans (Kadushin 1967:494). Adoption is culturally acceptable only when the couple is unable to conceive (Stroup 1966:376). Evidence from our exploratory study of women pregnant for the first-time supports this observation. For example, one woman had considered adoption when she thought she was unable to conceive; now that she was pregnant, she totally rejected the idea of having adoptive children in addition to her own "natural" children. Notwithstanding Lemasters' position (1970:171) that adoptive parents have several advantages over natural parents, Kirk (1959) has demonstrated several incongruous role expectations of adoptive parents. As Kirk noted (1959:316):

Conception, pregnancy, and birth involve more than biological and social facts: they represent important cultural goals which, at least in the context of marriage, are furthered by powerful positive sanctions.

Biological parenthood by pregnancy is the American norm; adoption is an undesired, deviant solution to the formation of a family.

Why is pregnancy so positively valued? Why do millions of American women seek to become pregnant, given the undeniable physical discomforts (and economic costs) of biological pregnancy? Psychological explanations have often been presented for the almost unanimous desire of Americans to have their "own" children. These explanations are beyond the scope of this paper. We do not doubt that part of the desire for pregnancy may come from innate, unlearned factors; from desires to display virility, extend one's ego, or compete with one's parents; from a deep-rooted liking of children; or from the psychological comfort received by a woman in having a mother role clearly defined for her (Pohlman 1969:50 ff.).

As sociologists, however, we are biased toward sociological explanations, explanations that focus upon the relationship of an individual to the structured inter-relationships we call society, and to the norms and values of that society.

Our thesis is that basic American values are strongly reaffirmed and supported by biological pregnancy. Using Vander Zanden's schema, we would argue that the latent social function of pregnancy is to affirm the values of success, progress, democracy, work and activity, and materialism. In the next few pages, we wish to suggest ways in which pregnancy can be viewed as supporting these aspects of the American value structure. Our comments are meant to be suggestive, not exhaustive; the reader will undoubtedly be able to add additional examples.

Consider success. In America, personal achievement is revered, while failure is viewed as a confession of weakness (Vander Zanden 1965:67). Pregnancy means success! First, the marriage is obviously successful since the couple is so happy with one another that they want to have children (or so the myth goes). Second, pregnancy indicates that the couple has been successful in having sexual relationships—indeed, pregnancy is the only institutionalized device couples have for openly admitting that they engage in sexual pleasures. The inability to conceive is a personal failure, a sign of weakness. When a couple cannot conceive, they are expected to seek counseling, medical assistance, and/or use folk cures. The American success theme of "if at first you do not succeed, try, try again" is obvious.

Third, since couples in the same social class tend to have children at the same ages as their peers, the wives who do not or who cannot conceive tend to become marginal members of their social group. Mrs. E., for example, said it made her feel better to be pregnant because she was one of the few members of the veterinary wives group who hadn't been pregnant until this time. Similarly, Mrs. W. reported that she had not cared for her student wives' organization because all of the other wives were either pregnant or had their first child, and she was still childless and working. She also remarked that she was now pleased that the news of her pregnancy would get around.

Fourth, if the couple cannot succeed and have their own children, their failure is underscored by their having to adopt someone else's unwanted (often illegitimate) offspring. Mrs. K., for example, said "I've always felt that if you could have your own, you know or at least you hope that is has fewer defects and it's just better... It's /adoption/ something that's sure a gamble—more of a gamble than having your own." Indeed, couples who can conceive but choose the path of adoption are sometimes suspect. As Kadushin (1967:440) noted:

If the couple is fertile but has deliberately chosen to complete the family through a legal procedure, one might legitimately question the degree of their acceptance of parenthood.

Finally, consider the rituals associated with pregnancy and compare them to those associated with adoption. How often are people embarrassed at the idea of a baby shower for an adopted child as opposed to a baby shower for a "natural" child? How often does one receive an announcement of the adoption of a child? How often do grandparents beam with pride over the adoption of their grandchild? In brief, pregnancy is success—adoption is failure.

MATERIALISM

A second, aligned value that pregnancy reaffirms is materialism. A man's success can usually be measured by the private property he possesses: the size of his house, the make of his car, his wife, his child. It is not enough to just have a child; the child must belong to the parents; pregnancy is the vehicle of ownership. In a capitalistic society, pregnancy supports the notion of private property—population limitation dramatically opposes the laissez-faire production of babies. Pregnancy reflects American materialism in other ways. Think about the attention given to the material sign that pregnancy exists. This physical abnormality is treated with awe, with reverence; consistent with materialistic values, the bigger the better. An entire folklore has developed around the timing, size, and position of the material manifestation of pregnancy. Special clothes have been devised to highlight the physical change; like a massive bandage on a child's minor cut, maternity clothes are worn early in the second trimester to highlight the wearer's physiological condition. Mrs. H. told us that her husband, who she thought was only mildly interested in the physical changes resulting from pregnancy, encouraged her to wear a maternity blouse even though she was only in her fourth month and able to wear ordinary street clothes. He encouraged her to do this even though their friends regarded the

new clothing as an overly elaborate (though amusing) display of their new social status. The relationship of pregnancy and materialism is underscored by the special prizes (diapers, playpens, furniture, etc.) which are often awarded to the first baby of the new year, and the attention given to twins, triplets, and other multiple births.

WORK & ACTIVITY

Besides success and materialism pregnancy also supports the American emphasis upon work and activity. A nine month period of physical discomfort and inconvenience can justifiably be rewarded with an offspring. Thus, there is a special irony in the thirty-two percent of adoptive parents in a study by Kirk who had been told by natural parents, "How lucky you are that you didn't have to go through all the trouble of pregnancy and birth like I had." (Cited by Kadushin 1967:494). This is especially ironic since pregnancy with its morning sickness and labor pains is almost a ritualistic event necessary for full womanhood in our society. Repeatedly, the women in our study remark that "there is something about having your own." Mrs. S. described her husband's opposition to adoption: "Just the idea that they're his—that they were made from me and him . . . really means a lot to him that the baby's there because of me and him and nothing else." The language of pregnancy is a language of work and activity: having a baby, making a baby, the miracle of creation, labor.

PROGRESS

A belief in progress, a fourth value, is also related to pregnancy. As Vander Zanden notes, "Americans tend to equate 'the new' with 'the best'." (1965:68). Becoming pregnant signifies faith in the society, belief in the future. In the American Dream, the child will have a better life than the parents. It is highly significant that individuals disaffected with the present and alienated from the future often decide not to have children, not "to bring them into this rotten world." Perhaps more than anything, pregnancy

reflects a firm belief and faith in a happy future, a sincere commitment to progress. Population limitation by the denial of pregnancy would be an admission that the future is clouded.

The hope of pregnancy was especially apparent to us during an interview with Mrs. C., a retarded dishwasher, pregnant for the first time. She wanted a boy who could take care of her if anything happened to her husband, and she believed he could become a preacher—far outreaching the achievements of herself and her husband (a small town handyman).

DEMOCRACY

Finally, pregnancy reaffirms the American ideal of democracy. Perhaps the statement, "All Men Are Created Equal," should be revised to read, "All Men Can Create Equally." The equal, unlegislated right to have children is a clear part of the democratic tradition. Americans have always had the freedom to have as many children as they desired; the exercise of this right has been a continual reaffirmation of this freedom. Contrast to this the warnings of population specialists that this right might some day have to be curtailed. In this perspective, the claims of black militants that birth control programs are attempts at black control are worthy of reflection. Since, as far as we know, the ability to conceive does not vary according to race, religion, or social class, pregnancy is the great equalizer.

DISCUSSION

In the preceding pages, we have sought to demonstrate that the social values supporting pregnancy are a serious dilemma for the population limitation advocates. The recent shift toward viewing population growth in the United States as an integral part of the world population problems has resulted in a dedicated effort to convince Americans that zero population growth must be achieved. By using Vander Zanden's seven major American values we attempted to indicate how the ZPG

movement was supported by the values of rationality and humanitarianism, but was opposed by the equally potent values of success, materialism, work and activity, a belief in progress, and democracy. We have suggested numerous ways by which pregnancy both reflects and reaffirms the latter five values. Thus, we have argued that attitudinal change toward a belief in the rational-humanitarian necessity of strict population limitation was not enough. Social values associated with pregnancy might ultimately prevent attitude change from resulting in behavior change; that is, while population limitation would be intellectually accepted by Americans, population growth would continue to occur.

At this point, three qualifications need to be added regarding our pessimistic conclusion. First, we do not assume that all Americans adhere strongly to all five values supporting pregnancy. Since our observations and interviews have taken place in a still predominately rural, small-town, mid-western state, our findings may reflect the conservative perspective of traditional America. On the other hand, our observations of the national culture do not lead us to conclude that these values are irrelevant in more cosmopolitan, more liberal environs. While all Americans may not adhere to these values, the themes of success, materialism, work, progress and democracy are such dominant referents in America's ideological structure that even those individuals who reject these values are forced to refer to their pervasiveness in their rejections. In short, success materialism - work - progress - and - democracy provide a backdrop against which the population crusade must be pictured.

Second, the values which encourage first pregnancies do not necessarily have to be relevant after the birth of one or two children. The ZPG goal could be achieved if the ideological impact of pro-natalist values were reduced after two children were born. Indeed, several of the women in our study voiced concern about limiting family size "...because of this population thing." Nevertheless, their pronouncements often

seemed to be without any positive ideological commitment. American emphasis upon materialism, success and progress does not include references to terminal benchmarks; acquisitiveness, striving, achieving are continual goals. In this context, we are forced to conclude (perhaps ponder is a better word) that the current pro-natalist values in American society will continue to be important determinants of childbearing behavior even after the birth of two children—especially when the rational-humanitarian pleas of population controllers become “old hat.”

Finally, the values we have discussed need not be considered inherently pro-natalist or anti-natalist. Indeed, the value conflict we have identified has developed because of a shift in the implications of rational and humanitarian concerns. Given eighteenth and nineteenth century infant mortality rates, life expectancy, agricultural yield and virgin land,

rational-humanitarian values encouraged pregnancy and population growth. Only recently have rational-humanitarian values been set in opposition to population increase. Indeed, this malleability of American values regarding childbearing is our direct concern. Population control advocates must concern themselves with reinterpreting all American values in terms of population limitation.

If those who favor population control are to succeed with their rational-humanitarian arguments, they will have to convince Americans that the values of success, materialism, work and activity, and democracy are not necessarily contradicted by the goal of zero population growth. Population control advocates must convince Americans that adherence to population limitation does not mean a commitment to a bleak future, and a repudiation of the American dream of eternal progress.

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NEO-NATAL MORTALITY & SOCIO-ECONOMIC STATUS IN A METROPOLITAN COUNTY

INTRODUCTION

In recent years the study of infant mortality has been supplemented in importance by studies of neonatal mortality. One of the major reasons for the increase in interest is that neonatal mortality has become more problematic than infant mortality. Advances in medical knowledge and increased technical skills have resulted in a sharp decrease in infant mortality during this century. For example even in the recent period from 1940 to 1967 for the United States the infant mortality rate decreased from 47.0 to 22.4 per 1000 live births.¹

However, as several authors have indicated, the decrease in the overall infant mortality rate has been attributable mainly to reductions in the postneonatal period.^{2,3,4} As Bogue points out when the quality of medical care is high and when death rates are relatively low, the large proportion of infant deaths will be in the neonatal period.⁵ In fact, for the United States in 1940 neonatal deaths accounted for approximately 61 percent of all infant deaths; by 1967 the percentage had

increased to 73 percent.¹ Thus, an understanding of factors associated with neonatal mortality is probably the area to concentrate on at present in order to make the greatest contribution to further reductions in deaths among infants.

LITERATURE

Studies have indicated that young women and older women tend to have higher neonatal mortality rates than women in their early and middle twenties; in addition, the number of previous viable pregnancies (parity) is associated with differences in neonatal mortality rates.⁶⁻¹⁰ The neonatal rate is usually high for first pregnancies, lower for the second pregnancy and then increases for successive pregnancies. Other studies have shown that race is an important variable, with neonatal mortality rates higher for nonwhites than for whites.^{1,5,11}

With respect to socioeconomic variables several studies have indicated that socioeconomic status is inversely related to neonatal mortality rates.^{3,12-14} The presumed reasons are generally thought to be the lack of financial resources to obtain medical help, ignorance of how to obtain help, poor education, or other social-environmental conditions. Such

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perspectives imply that women in lower socioeconomic classes do not, or perhaps are not able to, cope with pregnancy as adequately as women in higher socioeconomic classes with the result being higher rates of neonatal mortality. Benjamin¹⁵ has suggested that the short time interval "between birth and death renders it possible to assume that the social, economic, and cultural characteristics of the family at the birth of an infant . . . may be reliably assumed to operate up to the point of death and to be directly associated with death".

However, findings with respect to the inverse relation between socioeconomic status and neonatal mortality have been questioned. Neonatal mortality is thought to be closely associated with the physiological aspects of reproduction. Thus, as Stockwell¹⁶ and Donabedian¹⁷ have pointed out neonatal mortality would not be very sensitive to improvements in environment and socioeconomic status.

Willie¹⁸ and Willie & Rothney¹⁹ report that the significance of the relation between socioeconomic status and neonatal mortality may vary according to the way in which socioeconomic status is measured. Using a five factor index of socioeconomic status comprised of occupational, educational and housing characteristics, Willie & Rothney¹⁹ concluded that there was no significant association between socioeconomic status and neonatal mortality. However, using median family income as an independent variable, a negative association between income and neonatal mortality was observed.

In an attempt to clarify the situation, this study will examine the relation between the neonatal mortality rate and socioeconomic status, controlling for other relevant variables such as mother's age, parity and race.

THE DATA

The data for this study were taken from the vital statistics records in a large metropolitan county in the southern part of the United States. Neonatal mortality information was

collected and matched with the cohort of live births which were born during the calendar year 1967. Practical considerations in data collection dictated that neonatal death and live birth information be excluded if the death or birth occurred outside of the county. However, it was possible to obtain information on 93 percent of the live births and 93 percent of the neonatal deaths which occurred to residents of the county. In addition, the data were restricted to white and Negro deaths and births.

In the time period under consideration 237 neonatal deaths and 11,183 live births were available for study. These figures yielded a neonatal mortality rate of 21.2 per 1000 live births. For 232 of the neonatal deaths, complete information for the testing of hypotheses was available.

Using the Shevky-Bell index of social rank derived from 1960 Census data, an indicator of socioeconomic status was calculated for each census tract in the county.²⁰ The index of social rank has two components: an occupation score and an education score. The occupation score is the percentage of persons who are craftsmen, and foremen and kindred workers, operatives and kindred workers, laborers, except mine workers. The education score is the percentage of persons 25 and older who have completed eight years of school or less.

For each census tract the occupation and education scores were calculated separately and then standardized according to the procedure used by Shevky and Bell. The resulting standardized scores were then added together and divided by two to obtain the social rank score.

For the purpose of this study social rank scores of 39.9 or below will be referred to as the low socioeconomic status group and social rank scores of 40.0 or above will be referred to as the high socioeconomic status group.

From the information collected from the birth and death certificates, neonatal death rates were then calculated for the analysis to be presented in the forthcoming paragraphs.

PRELIMINARY HYPOTHESES & RESULTS

On the basis of available data and literature four preliminary hypotheses were tested using chi-square as a measure of association. For convenience in presentation, the data for the four hypotheses are given in Table 1.

The first hypothesis, that the neonatal mortality rate will be related to the number of previous viable pregnancies (parity), was confirmed at the .01 level of significance. The neonatal rate increased as parity increased.

The second hypothesis, that neonatal mortality will be related to the mother's age, was confirmed at the .01 level of significance. The highest neonatal rate (24.9 per 1000 live births) was observed for the under 20 age group while the age group 20-27 experienced the lowest neonatal rate (17.8 per 1000 live births).

The third hypothesis, that the neonatal mortality rate will be higher for Negroes than for whites, was confirmed at the .01 level of significance. The Negro rate was 25.8 per 1000 live births, while the white rate was only 16.2 1000 live births.

The fourth hypothesis, that the neonatal mortality rate will be higher in low socioeconomic groups than in high socioeconomic groups was confirmed at the .01 level of significance. The neonatal rate for the low socioeconomic group was 27.1 per 1000 live births compared to a rate of 17.4 per 1000 live births for the high socioeconomic group.

Finally, it was hypothesized that the neonatal mortality rate would be inversely related to socioeconomic status when the mother's age, parity and race were controlled. The analysis of variance technique with a $3 \times 3 \times 2 \times 2$ factorial design with one replication was used. The analysis failed to confirm the hypothesis at the .01 level of significance. Not only was socioeconomic status not significantly related to the neonatal mortality rate but none of the independent variables (race, age, parity) were related to the neonatal mortality rate when all the other variables were controlled.

The joint effect of mother's age and parity appears to be crucial for an understanding of causal factors related to neonatal mortality. It seems reasonable to suggest that physiological factors associated with age and parity, such as immaturity or congenital malformations, override the importance of race and socioeconomic status.

Since neonatal rates vary according to age and parity combinations, an attempt was made to identify those age-parity combinations which had the highest risk of neonatal mortality. Using the overall neonatal mortality rate of 21.2 as a cutoff point, those age-parity combinations with rates equal to or less than 21.2 were designated as low risk categories. The remaining category rates greater than 21.2 were designated as either medium or high risk categories.

The neonatal mortality rate for the low risk category was 15.3 per 1000 live births while the neonatal mortality rates were 23.9 per 1000 live births and 32.2 per 1000 live births for the moderate and high risk categories respectively. Since the moderate risk category contained relatively few deaths and live births, for subsequent analysis the high and moderate risk categories were combined.

It was found that the high and moderate risk categories were (1) all age groups at parity three or more, (2) women under 20 at parities 1 and 2, and (3) women over 27 at 0 parity. It is suggested that for the first two categories the high neonatal mortality rate may be due to the relatively close spacing of a large number of pregnancies which reduces reproductive efficiency. For the third category the high rates may be a result of conditions associated with fecundity and the risk of neonatal mortality.

Public health strategies to decrease neonatal mortality in high risk age-parity combinations may focus on well-defined population groups which also have a significant proportion of live births. Further analysis revealed that there are significant differences between socioeconomic and racial groups in the proportions of deliveries that occur in high and low risk categories.

Table 6 indicates that in the low socioeconomic category 41.1 percent of the live births occur in the high and moderate risk category compared to 28.6 percent for the high socio-economic- high and moderate risk category. A similar pattern is observed for racial differences in Table 7. Among Negroes 41.0 percent of live births occur in the high and moderate risk category compared to 26.8 percent for the white-high and moderate risk category.

DISCUSSION & SUMMARY

It is commonly realized that the use of census tract statistics presents some limitations. Since the index of social rank was based on the characteristics of groups of persons, inferences concerning individual behavior are limited. However, as a way of improving the reliability of results, future studies might calculate social rank scores separately for whites and Negroes, where such information is available, rather than calculating a score for the census tract as a whole.

Another limitation of the data was the time intervening between the publication of census data and its use for research purposes. In the present study, 1960 census data were used with 1967 vital statistics data. Obviously, many changes have occurred with respect to the socio-economic population characteristics of the census tracts during the intervening seven years. In an attempt to minimize difficulties presented by population changes two broad socioeconomic categories were used.

In spite of some of the difficulties involved, this study represents an advance in research design and analysis. First, the neonatal mortality rate has been examined with respect to socioeconomic status, mother's age, number of pregnancies and race. Prior studies in the United States, with the exception of Greenberg and Wells, have usually considered only two or three variables in their analysis.²¹

Second, this study represents an advance in terms of analytical techniques with the use of

analysis of variance. Previous studies have been largely content to point out by graphical presentation that differences do exist, but they have not been able to specify a confidence level for their results, using more powerful techniques of analysis.

The results of this study indicate that socioeconomic status, as measured by the Shevky-Bell index of social rank, is not related to the neonatal mortality rate when mother's age, parity and race are controlled. However, neither mother's age, parity or race was significant as main effects in the analysis of variance.

The analysis of variance employed in this study did indicate that age by parity interaction was significant which indicated that in terms of the neonatal mortality rate, the joint effect of age and number of pregnancies should be considered. The study suggests, therefore, that observed socioeconomic and racial differences in neonatal mortality result from the intervening effect of conditions of age and parity under which women in these groups conceive and bear children.

Given the above results and the subsequent introduction of risk categories as well as the percentage of live births by risk categories for race and socioeconomic status, it would seem that efforts for the reduction of neonatal mortality would be directed toward programs of family planning for Negro women and/or women living in low socioeconomic areas. Such efforts should be directed especially toward (1) women under 20 at parities 1 or greater, and (2) women over 20 at parity 3 or greater. The increased risk of neonatal mortality among women having their first pregnancy late in their reproductive years should be recognized; appropriate obstetrical services including preconceptional care should be made available and urged for all women desiring to have their first child at this point in their lives.

(Tables Follow)

Neonatal Mortality Rate by Parity,
Mother's Age, Race, and Socioeconomic Status

Parity	Deaths	Births	Rate/1,000 Live Births
0	72	4236	17.0
1-2	80	4301	18.6
3 and more	80	2646	30.2
	(232)	(11,183)	
	$P(X^2 \geq 15.62) < .01$		df=2
<u>Mother's Age</u>	<u>Deaths</u>	<u>Births</u>	<u>Rate/1,000 Live Births</u>
Under 20	69	2771	24.9
20-27	102	5737	17.8
28 and over	61	2675	22.8
	(232)	(11,183)	
	$P(X^2 \geq 5.38) < .10$		df=2
<u>Race</u>	<u>Deaths</u>	<u>Births</u>	<u>Rate/1,000 Live Births</u>
Negro	136	5270	25.8
White	96	5913	16.2
	(232)	(11,183)	
	$P(X^2 \geq 12.59) < .01$		df=1
<u>Socioeconomic Status</u>	<u>Deaths</u>	<u>Births</u>	<u>Rate/1,000 Live Births</u>
Low	118	4362	27.1
High	119	6821	17.4
	(237)	(11,183)	
	$P(X^2 \geq 11.88) < .01$		df=1

Table 2

Neonatal Mortality Rate by Socioeconomic Status,
Mother's Age, Parity and Race

Socioeconomic Status	N E G R O				W H I T E			
	P	Under 20	Age 20-27	28 & over	P	Under 20	Age 20-27	28 & over
LOW	0	26.1 (17/652)	33.3 (8/240)	00.00 (0/21)	0	12.2 (3/246)	4.3 (1/231)	32.3 (1/31)
	1-2	50.0 (16/320)	23.0 (12/521)	19.8 (2/101)	1-2	27.0 (3/111)	17.9 (8/447)	00.0 (0/130)
	3 & over	55.6* (1/18)	40.8 (16/392)	35.2 (18/512)	3 & over	00.0 (0/6)	16.4 (3/183)	30.0 (6/200)
HIGH	0	16.1 (7/436)	17.6 (8/455)	36.4 (2/55)	0	17.0 (10/587)	10.0 (11/1098)	21.7 (4/184)
	1-2	14.6 (3/205)	7.5 (4/534)	17.4 (3/172)	1-2	52.9 (9/170)	14.2 (16/1125)	8.6 (4/465)
	3 & over	00.0 (0/10)	31.6 (9/285)	29.3 (10/341)	3 & over	00.0 (0/10)	26.5 (6/226)	23.8 (11/463)

* For the analysis of variance this rate was treated as zero since the denominator was not judged to be large enough to warrant treating 55.6 as the observed rate.

Table 3

Analysis of Variance for the Neonatal Mortality Rate
by Socioeconomic Status, Mother's Age, Parity
and Race With the Second and Third Order
Interactions as the Error Term

Source of Variation	Sum of Squares	df	Mean Square	F	
Socioeconomic Status (SS)	14.82	1	14.82	--	n.s.
Mother's Age	65.55	2	32.77	--	n.s.
Parity (P)	30.19	2	15.10	--	n.s.
Race	195.54	1	195.54	1.349	n.s.
SS x Age	102.93	2	51.46	--	n.s.
SS x P	47.21	2	23.60	--	n.s.
SS x Race	236.64	1	236.64	1.632	n.s.
Age x P	3689.79	4	922.45	6.364	$p < .01$
Age x Race	190.84	2	95.42	--	n.s.
P x Race	35.88	2	17.94	--	n.s.
Error	2318.99	16	144.93		
TOTAL	6928.38	35			

Table 4

Neonatal Mortality Rate by
Parity and Mother's Age

Parity	Under 20	Mother's Age 20-27	28 and over
0	15.40 (37/1921)	13.83 (28/2024)	24.05 (7/291)
1-2	38.46 (31/806)	15.23 (40/2627)	10.37 (9/868)
3 and over	22.73 (1/44)	31.31 (34/1086)	29.69 (45/1516)

Table 5

Risk Categories by
Parity and Mother's Age

Parity	Under 20	Mother's Age 20-27	28 and over
0	Low Risk	Low Risk	Moderate Risk
1-2	High Risk	Low Risk	Low Risk
3 and over	Moderate Risk	High Risk	High Risk

Table 6

Combined Risk Categories by Socioeconomic Status

1. Percentage of Live Births

2. Neonatal Mortality Rate

Risk Category	Percent Live Births		Neonatal Rate	
	<u>Socioeconomic Status</u>			
	Low	High	Low	High
High and moderate	41.1	28.6	35.7 (64/1794)	27.7 (54/1949)
Low	58.9	71.4	19.9 (51/2568)	12.9 (63/4872)
	100.0% (4362)	100.0% (6821)		

Table 7

Combined Risk Categories by Race:

1. Percentage of Live Births
2. Neonatal Mortality Rates

Risk Category	Percent Live Births		Neonatal Rate	
	<u>R A C E</u>			
	Negro	White	Negro	White
High and moderate	41.0	26.8	34.7 (75/2159)	27.1 (43/1584)
Low	59.0	73.2	19.6 (61/3111)	12.2 (53/4329)
	100.0% (5270)	100.0% (5913)		

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THE ANTHROPOLOGY OF BIRTH

“When there is no more ethnology of primitive people, there will be an effort to understand man through those of his activities which, for one reason or another, are at the very limit of humanity.”

Claude Levi-Strauss¹

ASPECTS OF BIRTH CULTURE

The prototypical life crisis—birth—is a point of convergence for many lines of anthropological interest and allows a focussing on one of the most dramatic limits of humanity—that which defines life. The field of birth culture combines studies of physical and cultural anthropology with genetics and demography. Birth culture is concerned with marriage preference rules,

cultural limitations on the available gene pool, birth control or limitation of numbers which define the membership of a population, and with the definition of life itself. The study of birth combines cultural and psychological anthropology through the concept of identity, through the study of cultural influences on the chemical and physical environment of the unborn, and also by focusing on culturally prescribed modifications of the newborn. Most groups establish social identity through immediate ceremonies such as naming or through other means of formal induction into society. Folklore points up areas of concern to a people. All these patterns and procedures are of interest to the social scientist. They are a distillation of important values in a society. They define the acceptable member and give insight into the collective identity of the group.

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¹ As Quoted in Sanche de Gramont, There are no superior societies, *Claude Levi-Straus: The Anthropologist As Hero*, ed. E. Hayes & T. Hayes. (Cambridge: MIT Press, 1970, Reprint) 17.

Anthropologists study human behavior in most of its manifestations, but one question that has not been emphasized is how does a particular people take a newborn infant and make him a member of their group? What do they do to him and for him to assure that he will survive and that the group identity is firmly embedded in his consciousness?

Much of this is accomplished by the socialization process which goes on

throughout his early life—through education and habituation—and is legitimated and recognized through ritual and ceremony. Achieving personal identity is a lifetime occupation. However, certain practices acknowledge group membership immediately upon birth in all societies. Such acknowledgement is seldom explicitly regarded as identity establishment by the participants. Rather, people with an ideal in mind make the new recruit resemble their ideal as closely as possible.

Through cross-cultural comparison, we can demonstrate that cultural influence on the individual originates in prescribed and proscribed practices which define the beginning of human life, decide who is going to be born, specify some components of his genetic constitution, determine who will survive, and designate some ritual and ceremonial methods of assuring his compatibility with the social world into which he happens to have been born. The examples, except where otherwise specified, are drawn from a dissertation study resulting in the thesis *Culture and Perinatal Environment in American Society* (1965), based on observation and interviews with white and black clinic and private patients and their physicians in the San Francisco Bay Area of Northern California, and from comparative material compiled during subsequent field observations in Japan (1968), India (1968), and Sweden (1966, 1972).

The following description of the field of birth culture, while not exhaustive, is meant to suggest some perspectives for observation and some areas for research and analysis.

CULTURE & THE DEFINITION OF LIFE

Reflection on the philosophical question, what constitutes the beginning of human life? indicates the cultural nature of this issue—an issue with broad implications for behavior and for political decision-making. The geneticist Joshua Lederberg, in suggesting the continuum of life, has pointed out that scientific observation shows development to be a

gradual elaboration of the potentialities ultimately inherent in every cell. That is, there are no single specialized cells which alone can participate in this process—the sex cells are only some of many which have this capacity. There is no physiological infusion of life at a given point—there is only growth (v. Lederberg 1966). The decision as to when the growing, developing organism should be considered human is a cultural one based not on biology but on custom.

People in most societies have specific views on the beginning of human life (Knutson 1967). These informal definitions are usually consonant with institutionalized customary views of the society as a whole. For example, Hippocrates, in the Fifth Century B.C., postulated that humanity was accomplished at 30 days gestation for a male and 42 for a female (1952:59). Guttmacher (1967) has pointed out that "Aristotle agreed upon the earlier animation of the male embryo but put the times at 40 and 90 days respectively. Galen in a move toward equality for the sexes established the fortieth day for both male and female, a decision accepted by Roman civil law." Early English common law defined life as beginning at the time of "quickening." Quickening is an archaic term for the time around the fifth month of gestation when the fetus is felt to move. Thomas Aquinas defined the soul as the first principle of life and life is signalized by two actions, he stated, knowledge and movement. While the soul and knowledge of the unborn were not manifest, movement at five months gestation was unmistakable and Aquinas, too, postulated that this period of quickening was the beginning of a human life (Guttmacher 1967:4).

For others life begins with the first breath as which time the individual inhales a soul. Clellan Ford reports a society in the Solomon Islands where the infant is not touched nor the cord cut until the infant has breathed spontaneously which means the soul has arrived and the infant can be tended (1964:62). In other societies humanity is not established until after the first cry, or after the infant is named a member of his clan. According to Rajadon, in Thailand human

life begins after the third day. Before this the newborn is called a "spirit child" (1965:147). In India the tenth day marks the beginning of life.

These definitions of life all have one thing in common. There is generally no social recognition if growth ends before the culturally defined point at which human life is said to commence—that is, no funeral or ceremony is held. In India, if an infant dies before the tenth day naming ceremony, it is buried as a placenta rather than being cremated as a human being. In the United States and much of Western Europe, where life is considered to begin at birth, a stillbirth is marked by no ceremonial recognition. In the United States, however, the legal and customary definitions are incongruent. The law in many states defines life as beginning at conception. Interruption of life after conception is illegal. Changes in the law are eliminating this incongruity in some states, but it is clear that the codified custom of law must conform to the accepted definitions of the people or be doomed to transgression as many abortion laws have been. Laws or customary rules about abortion in any society are directly contingent on the currently accepted definition of life.

WHO SHALL BE BORN

Beyond the definition of life, there is the question, who will have life? Studies of this question require more than descriptions and analyses of the perinatal period. Many of the most important aspects of a person's chances for survival are determined before he is conceived. These are the demographic questions. Who is going to be born? What will his genetic constitution be?

The first cultural influences on population composition are marriage rules. Who is (and is not) allowed to marry and whom they marry dictate many characteristics of a population. There are natural limitations since people tend to choose people like themselves (Bell 1967:156). There are also legal and customary rules delimiting marriageable individuals for any group, and these

constitute cultural limitations. Rules about incest and miscegenation define categories of unacceptable mates for members of most societies. Rules of endogamy and exogamy define groups within which, or outside of which, one must marry for some societies.

In societies where status is fully or partly ascribed by birth, one of the most vulnerable points for high status members is maintenance of purity of line and hence correct parentage for members of the group (Berreman 1960:122-3). The higher the status, the more impossible it is to tolerate the misbegotten member. That is what Mary Douglas refers to as "avoiding improper mixtures" (1970:ix). Miscegenation laws are still on the books in many states of the United States. While these laws have been held unconstitutional by a recent Supreme Court decision, they clearly designated those groups, different for every state, that were not supposed to intermarry.

Anthropologists have for years been studying the marriage rules of groups of people. Genetic impact on the resulting populations, however, has not, traditionally, figured in kinship studies. More recently, anthropologically inclined demographers and geneticists have looked at the genetic implications of marriage preferences and kinship arrangements of various types.

In Andhra Pradesh, India, Sanghvi, in testing the extent of conformity to a marriage preference rule found that in this area forty percent of marriages were between first matrilineal cross cousins or maternal uncle and niece, and that another 2% were between patrilineal cross cousins (1967).

Jean Sutter in a historical demographic reconstruction of the genetic effects of birth control in France in the last two centuries found that limitation of gene pool coupled with a preference for local marriages created a situation of closer inbreeding than might be expected for an open system of marriage choice (1969:222).

Morton, Imaizumi and Harris in an investigation of clans as genetic barriers have proposed that "intermarrying clans represent

negligible genetic barriers," and further, that "sections and circulating connubia also have little effect on the mean coefficient of kinship between random individuals, but have larger effects on the coefficient of inbreeding, which in extreme cases may be nearly twice as great as in the absence of a prescribed marriage system" (1971:1005).

Neel, Yanase and Schull in "Consanguinity Studies in Japan" have suggested that if a consanguineous marriage preference is stringently followed, the resulting population will have certain characteristics that differentiate it for other populations. They found that mortality in pre-reproductive years of offspring of consanguineous marriages is increased over that of controls, there is heightened rather than lessened fertility, and that anthropometric measurements on children of inbred parents give larger dimensions than controls (1966).

These diverse studies suggest that there is still a broad range of necessary research to do using the most sophisticated of population genetics techniques before we can know the genetic meaning of various forms of family structure, and before we can identify who shall be born.

Another cultural influence on population composition is the use of birth control methods to limit the number of children born to any family (v. Newman in press). The dramatic reduction of the rate of population growth evidenced in the United States since the advent of easy, inexpensive, sophisticated methods of birth control attests to the influence of parental choicemaking on the number of infants born every year. People in other areas have used other methods, ranging from use of herbs similar to the "pill" to infanticide. The demographic consequences of these practices depend on the strength of custom as well as on other cultural elements such as belief, ideology, and family structure. In the United States, where private patients have had relatively easy access to birth control while clinic, county, and state patients in many states have not, the resulting fertility difference for "White" as opposed to "Negro and other" classification has had

far-reaching effects on the maintenance of poverty among disadvantaged minorities. Those least economically able to care for them have had the largest families, and this has tended to maintain class differences (Rainwater 1960). (Table I).

WHO SHALL SURVIVE?

Beyond the philosophic and demographic questions lies the medical question who will survive? Infant mortality, or death within the first year of life, has often been used as a health status indicator for the general public health of a nation (Yankauer, 1959).² Rate variation within particular societies cannot be accounted for on the basis of a national "health quotient," however, and other causes must be sought,

Birth culture in the United States and Western Europe is characterized by medical professionalism. In these areas, birth is not a private but a public matter. The law prescribes who may deliver babies, when abortions may be performed, how births and stillbirths are to be registered. In societies in which birth is still a family matter, the rules are handed down within the family, there are not limitations on practitioners, and registration of births, and particularly, of stillbirths or neonatal deaths may be problematic. It is useful, if difficult, to acknowledge a value difference that is reflected in different birth practices and to recognize a eugenic role for infant mortality in nations with a low standard of national health. Under these circumstances there may be a strong emotional investment in the viable child and less of a commitment to the nonviable one. Great care may not be exerted to revive the newborn showing signs of distress. In contrast, where health care is

² It has been argued that a better measure is childhood mortality from ages 1 to 6 and that infant mortality is more related to perinatal problems than to general health. Because this paper is on birth culture, it has been limited to the period of infancy, although the question of survival must of necessity also refer to childhood too.

good, because the practice of obstetrics in hospital under aseptic conditions has reduced the infant mortality rate, and because medical accountability is so closely tied to the fear of death, emphasis has been put on reviving the nearly nonviable, with intensive premature care and all the resources of complex technology brought to bear to avoid a death that might be attributed to hospital negligence. It is perhaps this difference in balance of values that promotes practices in developing countries that to the Western observer verge on infanticide.

But what of differential mortality rates between and within the developed nations? There has been great progress in the field of obstetrics. When the best medical care is available, when prenatal care is sought and doctors' orders are followed, when people are in good health to begin with and the obstetricians are well trained, the system works well. However, when prenatal care is not easily available and understaffed hospitals still defer to specialists, when poverty and malnutrition are standard, the cost in infant mortality is high. The best technology at delivery cannot make up for the poor health status of a lifetime.

Table II shows the dramatic differences in infant mortality that exist between Whites and Negroes in the United States. While the rates for both have decreased, a difference remains.

In the United States the immediate cause of death is often listed as prematurity—birth weight below five and one half pounds. For Black-White differences in median birth weight, see Table III. For low birth weight infants, mortality is only the top of the iceberg. More far-reaching effects of low birth weight are experienced by the surviving population in the form of what is euphemistically called "minimal brain damage" often not diagnosed until the school years, and effecting a recruitment for poverty that is both subtle and difficult to combat.

In Sweden, by contrast, most infants are born in hospitals, but almost all are delivered by midwives who are nurses with specialized

training. Sex education, beginning in gradeschool, emphasizes methods and value of birth control, that all should have prenatal care, and that for a woman to hear the first cry of her infant is one of life's greatest pleasures (requiring her to be non-anesthetized at delivery).³ Sweden's homogeneous population has little poverty, and good medical care is available to all. The combination of these factors produces the lowest infant mortality rate in the world.

Finally, survival is, to a certain extent, contingent on the great array of culturally prescribed rules for care of the newborn. Some of these practices have a direct effect on survival. The widespread custom of isolating mother and infant from the rest of society for a period of time immediately after birth serves the therapeutic purpose of protecting them from unnecessary contamination (Mean and Newton 1967:176-177). However, many culturally prescribed rules for care of the newborn are only indirectly related to survival. For example, the use of cowdung on the cord in India because of its religiously defined purity can result in a differential incidence of neonatal tetanus weighted to those who most carefully maintain the religious rules.

RITUAL DEFINITION OF STATUS

Of the many cultural questions relating to birth practices, one of the most dramatic relates to ritual acceptance of the newborn into society.

The first of many cultural celebrations of a lifetime is that in which one does not actively participate—that connected with one's own birth. Among Muslims in India and indeed, throughout the Muslim world, there is a ceremony performed on the first day of life

³ Current requests of Swedish women for more access to anesthesia in childbirth may act to change birth procedures as requested through four parliamentary motions introduced in 1971. These are summarized in the Special Social Committee recommendation based on motions about pain relief during delivery (Socialutskottets 1971).

called azaan in which a priest or elder speaks into the ear of the newborn the call to worship, to tell him, "God is One, and He has sent you." Most societies perform other, less specific ceremonies, which are comparable as media for communication. These customs tell the individual and the society who he is. Secondly, they reaffirm the group's identity. Birth rites may be said to establish a status for the newcomer and reestablish the status of the group.

Edmund Leach has suggested ritual as the dramatization of status and as social communication (1968:524). I would add that ritual dramatized the investiture and affirmation of status and that this is an important function for the maintenance of a social system. Whether the behavior can be called sacred or secular depends on social context and is not crucial. In fact some of the following examples move easily back and forth between sacred and secular without changing their essential content.

Naming ceremonies include rites of individuation and rites of incorporation. They present the new individual as a separate person with a unique name. At the same time, they acknowledge him as a member of his particular group.

The main birth ceremony in Japan is the naming ceremony held on the seventh day after birth. The most important aspects of the ritual performance are a paper on which the new name is carefully, and often beautifully, inscribed, and a family gathering including as many relatives, and sometimes neighbors, as possible, with gifts and food distributed to the assembled guests. Gifts are given at this time to the head of the family for the infant and his parents by participants in this ceremony and by some people who stand in a higher status than the new parents but are interested in their welfare: the father's employer for example, or perhaps, the go-between who introduced the couple. Traditionally, this ceremony has involved the naming paper being placed on the family altar at home. It has been considered a religious ceremony. At present, when many births take place away from home in a hospital or nursing

home and the mother and infant stay in the institution beyond the seventh day, the ceremony is performed wherever the mother and infant are. The ceremony must then include fewer people and the naming paper is placed on the wall. Food, including red rice, is served.

In reporting on this ceremony, many mothers remarked that theirs was not "religious" families, and that they did not have altars. In these families the paper was put on the wall at home and the ceremony was held in a secular manner with everything except prayers included.

Many women stated that the formal occasion was held for the purpose of securing agreement among family members as to the name. In this case the authority of the extended family is invoked. The occasion included the extended family and people of higher status, and gifts were directed to the head of the family.

In North India among the wealthiest and most orthodox Hindus, and among those who aspire to their status, the pandit is in attendance at the house (not in the room) of the birth. A conch tone heralds the birth, and the pandit then retires to his charts to determine the astrologically auspicious initial for the name and to make important predictions about the newborn's future. The naming ceremony for Hindus usually occurs in conjunction with the tenth or eleventh day ceremony and consists of a puja (the central religious ritual) the pronouncing of the name by a pundit or an elder in the family, and the distribution of food to relatives and friends. The ceremony may, however, take place on the sixth, tenth, eleventh, twenty-first or fortieth day depending on convenience and the rules of the particular subgroup. There is great variation as to which of these ceremonial days is emphasized by naming the infant. They are all ritual bath days which mark, in van Gennep's terms, way stations in the mother's lessening of birth pollution, hence reincorporation into social life (1960:46-8). The forty days are her period of transitional status. As the infant's hold on life becomes firmer, he too is more of a member

of the group, but his transitional status lasts longer—until initiation, with other points along the way marking his progress.

The cultural context of group membership in India is, for both family and caste, maintained by religious validation. The public performance is conducted by the pandit, representative of religion. Naming is a religious act. Anything associated with naming or birth tends to take on religious significance also, and so it was not surprising to find religious ritualization of manifestly secular processes. An example of this would be the holding of the Health Department's birth certificate on the family altar until the eleventh day ceremony. On this occasion the certificate is filled out by the pandit and returned, as it was procured, by the ritually prescribed person (usually the sweeper) who takes care of other birth-related procedures such as disposing of the placenta.

Naming, in the United States, is often an informal procedure. Birth certificates (hence choice of names) are made out in hospitals, where most births take place—an entirely secular function. Announcements with name, parents, birth weight are mailed out to friends and relatives; gifts are sent in return. Gifts in this case are directed to the infant addressed by his new name. Choice of name is left to the parents except among ethnic groups who maintain traditional naming rules. For those who participate in religious systems there are religious naming rituals. Christening and baptism involve both religious and social ritual including distribution of food and gifts for the newborn.

The dramatization of interaction between primary group (nuclear or extended family) and society at large is clear in recruitment situations and investiture, and especially clear as an aspect of naming ritual. The ritual behavior in each case is public. It is validated by an authority of the society at large—in Japan the family members, in India the family priest, in the United States the personal community of friends and relatives. As noted above, in Japan the ceremonial occasion includes achievement of agreement, particularly among older members of the family, as to the appropriateness of both

sound and characters of the name.

An aspect of further secularization of naming in the United States is the exercise of authority of local Boards of Health which can reject obscene or what they consider to be inappropriate names, for example, or an ultimate secularization—the issuance of a birth number as in Sweden or a social security number on entrance to school as is suggested in the United States. In each case the authorities of the larger society stand in a position to exert social control in a more or less formal way as well as to affirm or deny the citizen status claims of the individual parents.

Marcel Mauss, in *The Gift*, has identified reciprocity as an expression of social recognition of interaction—mutual gift-giving as validation of a relationship (1954:11). The gift which sets up a moral obligation to reciprocate, immediately or sometime in the future, invests a continuity to the relationships between members of the society and an enduring nature to the claimed status of the individual and his family.

In Japan, at the naming ceremony, gifts are given by participants and other interested persons to the head of the family for the infant and for his parents. Food, including red rice for good luck, is given by the family to the guests assembled for the ceremony. In India, the religious ceremony is private. Gifts, including money and food, are given to the pandit as payment for his role in the naming procedure. After the private ritual, a public ceremony is held with the extended family cooperating to meet expenses and help with preparation. Foods—mainly sweets—are distributed as widely as the family can afford—at least to those related in any way and to immediate neighbors, and if possible food is given to the entire village or neighborhood. In the United States, gifts are brought or sent to the infant himself. If there is a naming ceremony, food is provided for the guests by the parents. Cigars are traditionally distributed to men by the new father. In each of the examples presented, gifts are given in honor of the infant and food is distributed, but the givers and receivers are different.

One final aspect of the language of ritual is the intensity of adherence to the rules. Ceremonies are notoriously expensive and birth ceremonies are no exception. Here I refer specifically to the Indian case. While participation in, and solidarity within, society are communicated by ritual behavior, the elegance with which the ceremony is carried out must be part of the communication. In this respect ritual is an intensifier of the status quo (or status aspirandum). Those who gain most from the solidarity of the group are best able to adhere elegantly to the letter of the ritual law. The Brahman may hire a band to celebrate the naming of a son on the eleventh day. The Brahman's sweeper on his son's naming day, will borrow money to distribute sweets at least to his neighbors. The important thing is a statement made on behalf of the primary group to the community. The

sweeper's statement says, "a baby has been born." The Brahman's says, "A baby of high status has been born." Rituals of incorporation including the naming ritual with its various primary participation groups, its reciprocity of gift giving and food distribution help to identify the new one with the group with which he is to be aligned for the rest of his life.

The Anthropology of Birth includes many issues not touched upon here. These questions are meant only to suggest some of the richness of variety of cultural accretions on the biological processes relating to birth. This has indeed not been an exhaustive list, but is, rather, an attempt to present some of the many possible areas for research and observation at this particular "limit of humanity."

(Tables Follow)

Table I

BIRTH RATES: 1950 TO 1968*

(In thousands, except as indicated. Prior to 1960, excludes Alaska and Hawaii. For 1950 and 1955, births adjusted for underregistration; thereafter, registered births. For population bases used to derive these data, see text, p. 45. See also Historical Statistics, Colonial Times to 1957, series B 6 and B 19-21)

	1950	1955	1960	1963	1964	1965	1966	1967	1968
Birth rate per 1,000 population _ _ _ _ _	24.1	25.0	23.7	21.7	21.0	19.4	18.4	17.8	17.5
White _ _ _ _ _	23.0	23.8	22.7	² 20.7	20.0	18.3	17.4	16.8	16.6
Negro and other _ _ _ _ _	33.3	34.7	32.1	² 29.7	29.1	27.6	26.1	25.0	24.2

²Excludes data for residents of New Jersey since this State did not require reporting of race.

* U.S. Bureau of the Census. 1971. P. 48.

Table II

INFANT AND MATERNAL DEATH RATES, BY RACE: 1940 TO 1968*

(Deaths per 1,000 live births, except as noted. Prior to 1960, excludes Alaska and Hawaii. See also Historical Statistics, Colonial Times to 1957, series B 101-112)

ITEM	1940	1945	1950	1955	1960	1965	1966	1967	1968 (prel.)
Infant deaths ¹ -----	47.0	38.3	29.2	26.4	26.0	24.7	23.7	22.4	21.7
White -----	43.2	35.6	26.8	23.6	22.9	21.5	20.6	19.7	(NA)
Negro and other -----	73.8	57.0	44.5	42.8	43.2	40.3	38.8	35.9	(NA)
Maternal deaths ² -----	376.0	207.2	83.3	47.0	37.1	31.6	29.1	28.0	(NA)
White -----	319.8	172.1	61.1	32.8	26.0	21.0	20.2	19.5	(NA)
Negro and other -----	773.5	454.8	221.6	130.3	97.9	83.7	72.4	69.5	(NA)

NA Not available. ¹Represents deaths of infants under 1 year old, exclusive of fetal deaths.

²Per 100,000 live births from deliveries and complications of pregnancy, childbirth, and the puerperium. Beginning 1960, deaths are classified according to seventh revision of International Lists of Diseases and Causes of Death; see text, p. 45.

Table III

BIRTH WEIGHT, BY RACE: 1950 TO 1968*

(Prior to 1960, excludes Alaska and Hawaii. Represents registered births.)

	MEDIAN BIRTH WEIGHT ²							
	1950	1955	1960	1964	1965	1966	1967	1968
Total-----	71b.5oz.	71b.5oz.	71b.5oz.	71b.4oz.	71b.4oz.	71b.4oz.	71b.4oz.	71b.4oz.
White-----	71b.5oz.	71b.5oz.	71b.6oz.	71b.5oz.	71b.5oz.	71b.5oz.	71b.5oz.	71b.5oz.
Negro and other-----	71b.3oz.	71b.1oz.	61b.15oz.	61b.14oz.	61b.14oz.	61b.14oz.	61b.14oz.	61b.14oz.

²Median (definition from the preface): The value which divides the distribution into two equal parts - one-half the cases falling below this value and one-half exceeding it.

* Adapted from U.S. Bureau of the Census. 1971. P. 49.

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URBAN LIFE & BREAST FEEDING:

A Sociological Analysis

INTRODUCTION

Aside from ethnographic descriptions, the first social study that covered infant feeding was probably the national survey in the U.S. reported in 1936.¹ A small number of selected sociological studies have examined infant feeding practices since that time.² The best known are a series of childrearing studies which began with an article by Havighurst &

Davis in 1946.³ An outstanding treatment was the review of previous studies by Urie Bronfenbrenner in 1958.⁴

¹ Anderson, *The Young Child in the Home*. Report of the committee on the Infant & Pre-school Child, White House Conference on Child Health and Protection (New York: D. Appleton-Century, 1936).

² K. Bain, Incidence of breast feeding in hospitals in United States, *Pediatrics* 2 (1948) 313-19; F. Hytten, Clinical & chemical studies in human lactation, part 8, *British Medical Journal*, 2 (1954) 844; F. Hytten & A. Thomson, Clinical & chemical studies in human lactation, Part 10, *British Medical Journal* 2 (1955) 232-37; H. Meyer, Breast feeding in the United States: extent & possible trend, *Pediatrics* 22 (1958) 116-21; D. Horn & E. Solomon, The frequency of breast feeding in a representative sample of women in a metropolitan area, *Cancer* 12 (1959) 191-92; E. Prothro, *Child Rearing in the Lebanon* (Boston: Harvard University Press, 1961); W. Robertson, Breast feeding practices: some implications of regional variations, *American Journal of Public Health* 51 (1961) 1035-42; L. Newson & E. Newson, Breast feeding in decline, *British Medical Journal* 2 (1962) 1744-45; H. Meyer, Breast feeding in the United States: report of a 1966 national survey with comparable 1946 & 1956 data, *Clinical Pediatrics* 7 (1968) 708-15.

³ A. Davis & R. Havighurst, Social class & color differences in child rearing, *American Sociological Review* 11 (1946) 698-710; M. Ericson, Child rearing & social status, *American Journal of Sociology* 53 (1946) 190-92; E. Maccoby & P. Gibbs, Methods of child rearing in two social classes, *Readings in Child Development*, ed. W. Martin & C. Stendler (New York: Harcourt, Brace, 1954); W. Sewell et al, Relationships among child training practices, *American Sociological Review* 20 (1955) 137-48; R. & A. Davis, A comparison of the Chicago & Harvard studies of social class differences in child rearing, *American Sociological Review* 20 (1955) 438-42; R. Littman et al, Social class differences in child rearing: a third community for comparison with Chicago & Newton, *American Sociological Review* 22 (1957) 694-704; M. White, Social class, child rearing practices & child behavior, *American Sociological Review* 22 (1957) 704-712; W. Boek et al, *Social Class, Maternal Health & Child Care* (Albany: New York State Department of Health, 1957); D. Miller & G. Swanson, *The Changing American Parent* (New York: John Wiley, 1958); M. Hernstein, *Child Rearing in California* (Berkeley: California Department of Public Health, 1965).

⁴ U. Bronfenbrenner, Socialization & social class through time & space, *Readings In Social Psychology*, ed. E. Maccoby, T. Newcomb & E. Hartley (New York: Henry Holt, 1958) 400-25.

Paper presented at the annual meeting of the Eastern Sociological Society, New York, April 1972.

In 1965 an advisory group of the World Health Organization indicated that studies of the impact of urbanization on infant feeding practices were imperative.⁵ As early as 1946 Justus Strom reported a lower rate of breast feeding for metropolitan medical centers than in suburban and rural centers in Sweden.⁶ Urban factors in infant feeding practices had been suggested in a survey of infant malnutrition in sub Saharan Africa by Derek Jellife.⁷ A similar finding was reported by Nancie Solien de Gonzales in 1963 for Guatemalan migrant families, for whom breast feeding decreased with increasing exposure to the city.⁸ There has been no effort to analyze the relationship between exposure to city life and infant feeding practices in an effort to explain this phenomenon. This is a report of an analysis of the effect of urban culture on infant feeding in an American community.⁹

METHODOLOGY

The data reported in the present investigation are from a survey of women in Buffalo, New York. The survey was supported by the American Cancer Society. A representative sample of women forty years of ages and over who could be assumed to have completed

their child-rearing history was selected for study. Every woman of appropriate age in a two percent probability sample of addresses was selected for study. Interviewing was done by nurses who received interviewer training. An analysis of interviewer reports showed that interviews were successfully completed with eighty-six percent of the women fulfilling the age criterion. The rate of refusals and part-refusals was eleven percent. The remainder, three percent, were not interviewed for reasons such as senility, deafness, or illness.

Since normal sociological patterns were the object of this study, we excluded mothers of multiple children, premature children, low birthweight children, and mothers whose first livebirth did not survive the first year. Also excluded were mothers with incomplete information on significant research variables.

The present concern is with life styles that arise in urban and rural settings. We assume that the greater the exposure to a setting, the more likely it is that the exposed person will take on the distinctive cultural patterns which developed in that setting. So the mothers are classified according to the proportion of their lives spent in cities of over 10,000 persons at the time when they had their first child.

RESULTS

The hypothesis that breast feeding decreased as the exposure to city life increased was tenable. The more time a woman had spent in cities when her first child was born, the less likely she was to breast feed it, and if she did breast feed, the less likely she was to keep breast feeding for an extended period (Table 1). Whereas eighty-seven percent of the lifetime rural residents breast fed their children, only seventy-seven percent of the lifetime city residents did so. In the same way, nearly two-thirds (65 percent) of the lifetime rural residents breast fed for more than six months compared to less than one-half (40 percent) of the lifetime city residents. There was a regular gradient, with mothers who migrated to cities before the birth of their children in an intermediate

⁵ World Health Organization, Physiology of lactation, *Technical Report Series no. 305*, Geneva, Switzerland, 1965.

⁶ J. Strom, The Falling rate of breast feeding in Sweden, *Acta Paediatrica* 45 (1956) 453-55.

⁷ D. Jellife, Culture, social change & infant feeding, *American Journal of Clinical Nutrition* 10 (1962) 19-45.

⁸ N. Solien de Gonzales, Breast feeding, weaning & acculturation, *Journal of Pediatrics* 62 (1963) 577-81.

⁹ The survey was directed by Saxon Graham, then at Roswell Park Memorial Institute, currently at the State University of New York at Buffalo. The data analysis, which was the basis for a doctoral dissertation submitted to Yale University, was supported in part by the National Institute of Mental Health, USPHS Training Grant 7098.

position. Urbanism, or exposure to city life, was related to the selection of a method of infant feeding.

The next step was to determine what variables may have accounted for the relationship between city life and infant feeding practice. A number of study variables were associated with both exposure to city life and breast feeding pattern (Table 2). Women who saw themselves as unable to breast feed were, of course, less likely to start or maintain breast feeding than women who reported not breast feeding or stopping for cosmetic or other personal reasons. The year in which the child was born was significant, for a decline in breast feeding over the years has been rather firmly established. In the decade following 1900, nine out of ten mothers breast fed their children. By 1950, one-half did not breast feed at all. The drop in long term breast feeding was even more striking, since eighty-seven percent of the mothers breast fed over six months in the decade after 1900, but only seven percent of the mothers breast fed over six months after 1950. Closely related to year of childbirth, the use of a hospital for childbirth was associated with a reduced likelihood of starting or maintaining breast feeding. It may be a surprise to many that quite a few women now over fifty had their first child at home. The more highly education a mother was, the less likely she was to begin breast feeding or to maintain it.

The study mothers were older women, so we saw no evidence of the frequently discussed resurgence in breast feeding which may be taking place among younger and college-educated women. Female employment was cited as a major factor in the decline of breast feeding in the child rearing literature, but it seemed to have very little effect on the probability of starting breast feeding. Women who went to work in the year after childbirth were less likely to breast feed over six months than those who were never employed. Interestingly, those mothers who had worked before but not in the year following childbirth reported a pattern just like the working mothers. Female employment may be less important as a direct interference than as an indicator of a liberation of the woman

from her traditional role. There was a tendency for breast feeding to be started more often and maintained longer as the family descended in occupational status, but the trend was not as clear or as strong as might have been hypothesized from the child rearing literature. The next step was to examine the relationship between exposure to city life and breast feeding, controlling for each factor in turn.

The effect of urban exposure was not entirely attributable to any of the studied test factors; for the relationship did not entirely disappear when controlling for any specific study variable (Table 3). However, the conditions under which the relationship between city exposure and the method of infant feeding was reduced may increase our understanding of how city life affects people. Urban-rural differences in infant feeding practices diminished among women who were highly educated, who had been employed outside the home, who were unaware of whether they themselves had been breast fed, or who saw themselves as physically unable to breast feed. In general, when rural women had social and personal characteristics similar to what most city women had, their infant feeding practices were similar. Yet when city women had social and personal characteristics more often found in rural women, the city women still breast fed less often and for a shorter time. This situation may reflect anticipatory socialization or simply that there are many ways to break away from the traditional female role; living in the city is just one of them, while getting an education and becoming employed may be others.

CONCLUSION

The assumption that exposure to urban society was associated with a decrease in traditional breast feeding was supported in this investigation. The effect of city life was not entirely attributable to any studied characteristic associated with exposure to city life. In no case was the direction of the relationship reversed, and it was reduced only under conditions that may be indicators of a breaking away from a traditional role for women.

The pattern of findings tells us something of the way in which city life acts upon tradition. A unitary factor may underlie all of the conditons which reduce traditional patterns of breast feeding. Urbanism, female employment, hospital use for childbirth, and formal education all reflect increased participation in social systems outside the home. Whatever the implications of female employment, it would not have occurred if the traditional role of women had not considerable changed. If the attachments to the home had remained substantial, the site of

childbirth would not have shifted from the home to the hospital. Educated women, for instance, would not be receptive to child rearing experts and the child rearing literature if they possessed clear traditional guidelines. This does not deny that the distinctive characterisites of each factor may not play a role but suggests that the major mechanism may simply be the disengagement of women from home-based traditional systems. The study also suggests that the urban-rural distinction may still be useful in sociology.

(Tables Follow)

TABLE 1. BREAST FEEDING STATUS
BY DEGREE OF EXPOSURE TO URBAN SOCIETY
BUFFALO, NEW YORK

	<u>Percent of Mothers</u>			Total Percent	Total No.
	Not Breast Feeding	Breast Feeding Under 6 mos.	Breast Feeding Over 6 mos.		
1. Degree of Exposure to City					
High	23	37	40	100	(589)
Medium*	19	29	52	100	(297)
Low*	13	22	65	100	(114)
Total	21	33	46	100	(1000)

High- Entire life in city to birth of first child

Medium - Migrated to city before birth of first child

Low - No exposure to city before birth of first child

*Combined for χ^2 and further analyses.

$\chi^2 = 29.33$, $df = 2$, $p < .001$

TABLE 2. BREAST FEEDING STATUS OF MOTHERS BY FACTORS RELATED TO EXPOSURE TO URBAN SOCIETY^a — BUFFALO, NEW YORK

	<u>Percent of Mothers</u>			Total Percent	Total No.
	Not Breast Feeding	Breast Feeding Under 6 mos.	Breast Feeding Over 6 mos.		
1. Perceived Ability					
Able	9	16	75	100	(571)
Not Able	35	56	9	100	(429)
2. Year of Child- birth					
pre-1900	7	7	86	100	(15)
1900-1909	14	10	76	100	(81)
1910-1919	15	18	67	100	(202)
1920-1929	19	33	48	100	(274)
1930-1939	20	45	35	100	(273)
1940-1949	34	47	19	100	(141)
1950-1959	50	43	7	100	(14)
3. Location of Childbirth					
Home	16	23	61	100	(517)
Hospital	25	44	31	100	(483)
4. Education (Yrs. of school completed)					
College					
Graduate (16+)	44	37	19	100	(27)
College (13-15)	24	53	23	100	(59)
High School					
Graduate (12)	26	47	27	100	(141)
High School (9-11)	25	34	41	100	(230)
Grammar School					
Graduate (8)	17	33	50	100	(252)
Grammar School (1-7)	15	22	63	100	(262)
None (0)	14	10	76	100	(29)

TABLE 2. BREAST FEEDING STATUS OF MOTHERS BY FACTORS RELATED TO EXPOSURE TO
(cont'd) URBAN SOCIETY^a — BUFFALO, NEW YORK

		<u>Percent of Mothers</u>			
		Not Breast Feeding	Breast Feeding Under 6 mos.	Breast Feeding Over 6 mos.	Total Percent Total No.
5. Female Employment Status					
	Never Employed	20	26	54	100 (534)
	Employed Before But Not within Year after child- birth	20	41	39	100 (395)
	Employed Within Year After Childbirth	24	39	37	100 (71)
6. Husband's Occupation Status					
	I Professional	26	47	17	100 (38)
	II Managerial	21	38	41	100 (86)
	III Clerical & Sales	22	42	36	100 (130)
	IV Skilled	24	32	44	100 (230)
	V Semi-skilled	18	32	50	100 (370)
	VI Unskilled	18	23	59	100 (146)

^aProbability < .001 for all variables, dichotomized at or near median.

TABLE 3.

MAGNITUDE OF THE RELATIONSHIP BETWEEN
BREAST FEEDING STATUS OF MOTHERS
AND EXPOSURE TO URBAN SOCIETY
CONTROLLING FOR EACH IMPORTANT TEST FACTOR.
BUFFALO, NEW YORK

Test Factor	Measure of Association ^a
1. Perceived Ability	
Unable	-.045
Able	-.141*
2. Year of Childbirth	
Before 1925	-.110*
1925 & After	-.110*
3. Location of Childbirth	
Hospital	-.126*
Home	-.126*
4. Education	
High (more than 8 years)	-.071
Low (8 Years or less)	-.164*
5. Female Employment	
Ever Employed	-.071
Never Employed	-.155*
6. Occupational Status of Husband	
White Collar	-.114
Blue Collar	-.152 *
Uncontrolled Relationship, Urban Exposure and Infant Feeding	-.155*

*p < .05, direction predicted

^aMeasure of association is Phi, defined as the square root of x^2/N .

^bBased on a comparison of medium and low degrees of urban exposure.

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FAMILY SIZE PREFERENCES & SEX COMPOSITION

INTRODUCTION

There is a line in that old song "Tea for Two" which goes something like this—"And we shall raise a family, A boy for your, a girl for me." As everyone knows, things don't always happen as they do in songs, and the boy for you and girl for me may turn out to be two girls, or three boys, or even four girls and, at last, a boy.

The purpose of this paper is to analyze the relationship implied by this refrain. Does there exist among Americans a desire for a balanced family sex composition, or at least one child of each sex, and does this desire serve as an intervening variable between family size preferences and actual fertility?

This paper is restricted to a consideration of initial family size preferences and their modification under differential hypothetical sex compositions. The investigation of family size preferences in fertility-related surveys is important for a number of reasons. One, questions on family size preferences generate kinds of information unavailable through an ex post facto approach. For example, they enable us to ascertain fertility norms which, when compared with actual fertility, give us a measure of the error component of fertility behavior. Two, stated family size preferences have been found to have high aggregate

predictive value and can be used, with caution, as an aid in family size and population projections.¹ Three, as women become increasingly sophisticated with the use of contraceptives, fertility desires and expectations can be expected to coincide more and more with actual performance.

The analysis will be in three main sections—a discussion of family size consensus; a brief review of studies that have measured sex preference; and a presentation of findings from a preliminary study relating the two factors, which we feel has broad implications for fertility-related theory and research.

FAMILY SIZE CONSENSUS

A major finding of national fertility surveys is that American women prefer families of two through four children. About nine out of ten women consider either two, three, or four children as ideal. And over eighty per cent expect their completed families to fall within this range.²

¹ C. Westoff, E. Mischler & E. Kelly, Preferences in size of family & eventual fertility twenty years after, *American Journal of Sociology*, 42 (March 1957) 491-97.

² P. Whelpton, A. Campbell & J. Patterson, *Fertility & Family Planning in the United States* (Princeton: Princeton University Press, 1966) 33-37.

The 1965 Growth of American Families survey indicated an apparent bimodality of desires (values of two and four more likely than three) among women who have completed their childbearing.³ When three-parity women of completed fertility were asked how many children they "really wanted" a significant proportion indicated they wished two or four.⁴ In every analytic category studies with one exception (Negro, high school completed), the proportion satisfied with three children was smaller than for those with two or four children.

A number of questions are raised by these results. Why is there such a strong two through four child bias among American women? What is there about two and four children that seem to make those numbers particularly desirable for women of completed fertility? Little work has been done on these questions. One suggestion is that Americans have a distaste for an "only child" and that this also expresses itself as a smaller than expected desire for three children, which can be viewed as two plus an only child. Another suggestion is that children are easier to raise "two at a time." A third and seemingly more plausible reason is that Americans desire children of each sex, and particularly idealize a sex balance. Thus, the two through four child preference range might exist because Americans want to have at least one child of each sex, and the achievement of this goal is possible for the majority of couples within the two through four range. Two and four children might be especially preferred because of the sex balance seemingly implicit in those numbers. Let us investigate this notion more thoroughly.

SEX PREFERENCE

In one of the few studies in which sex preference is a major focus of the research, Dinitz, Dynes and Clark asked 380 college

students which sex they would prefer for an only child. They report that 76 per cent specified a boy and 24 per cent a girl.⁵ In the 1960 Growth of American Families study conducted by Whelpton, Campbell and Patterson it was found that two-thirds of the men and women quoted an ideal comprised of equal numbers of girls and boys.⁶ But of the remaining one-third, 64 per cent reported an ideal in which boys outnumbered girls. This slight preference for boys made for a sex ratio of 106-107, quite similar to the actual sex ratio at birth in the United States.

The most relevant studies of sex preference, and the first to link together sex and family size preferences, are the Princeton Studies, reported in *Family Growth in Metropolitan America*⁷ and its follow-up, *The Third Child*.⁸ In 1957, the beginning of this longitudinal study, all couples were of two-parity. Each couple was asked how many children they desired, counting the two they already had. The mean desires for couples, grouped according to sex composition of the first two, are given in Table 1A. Couples who already had one child of each sex were most satisfied and desired the lowest completed family size. Those who had two girls were least content. Couples were reinterviewed three and one-half years later and at this time, the average of additional pregnancies which occurred, by composition of the first two, are shown in Table 1B. As expected, couples with two children of the same sex had more pregnancies in the interim period than couples with both a boy and a girl. Thus, the Princeton study findings suggest that an important interrelationship exists between sex

⁵ S. Dinitz, R. Dynes & A. Clarke, Preferences for male or female children: traditional or affectional? *Marriage & Family Living* 16 (1954) 128-30.

⁶ P. Whelpton, A. Campbell & J. Patterson, *Fertility & Family Planning in the United States* 35.

⁷ C. Westoff, R. Potter, P. Sagi & E. Mischler, *Family Growth in Metropolitan America* (Princeton: Princeton U. Press 1961)

⁸ C. Westoff, R. Potter & P. Sagi, *The Third Child* (Princeton: Princeton U. Press 1961).

³ N. Ryder & C. Westoff, Relation among intended, expected & ideal family size: United States 1965, *Center for Population Research* (March 1969) 7-8.

⁴ Ibid.

composition preferences and preferred and actual family size.

Myers and Roberts, in a recent article, go further in relating the two dimensions.⁹ They reported a method of testing the interrelationship between size and sex composition in which women make quantitative choices between 1176 different childbearing patterns. The method "produces a mapping of preferences for different family sizes and compositions and enables one to establish subjective distances between various combinations." A pilot study of 18 Puerto Rican women using this method indicates that "family balance is very important to these women." The women preferred first, a family pattern of two boys and two girls, second, one boy and one girl, and third, two girls and one boy. Myers and Roberts conclude from this that for these women, "composition may be a more important aspect of choice than total size."

RESULTS FROM A PRELIMINARY STUDY OF SEX COMPOSITION & FAMILY SIZE PREFERENCES

In order to investigate this relationship in greater depth and at the same time with greater ease, a technique was developed for survey research that determines an individual's preferred family size and sex composition considering all childbearing patterns up to four parity. These are shown in Figure 1. The 14 combinations of boys and girls are presented in random order. Individuals are asked to place themselves into each childbearing situation and indicate for each the number and sex of additional children they would like, if any. Two undergraduate sociology classes at Duke University participated in a preliminary study that incorporated this method. Seventy-three students, roughly half coeds, completed the questionnaire.

In response to the control question, "If you

could have as many children as you want, and then stop, how many children would you have?" the majority of the students—87 per cent—cited a preference for two, three, or four children, with 47 per cent citing two. A slight bimodality was indicated with four children slightly more preferred than three. Table 2 shows the proportion of students desiring each number of children.

The students also were asked to indicate the sex composition they would want for their desired number of children. As Table 3 shows only a small percentage desired a childbearing pattern consisting of a single sex or no children. A larger proportion (90%) specified at least one child of each sex, with nearly two-thirds indicating a sex balance. Forty-two per cent wish one boy and one girl, and 19 per cent two boys and two girls. Thus, most students prefer family sizes of two through four children and want at least one boy and one girl. A balanced family is the most preferred, with two boys and one girl a second choice. In thinking about their future roles as parents, college students appear to show considerable consensus as to what is a desirable sex composition as well as size for a family.

Table 4 shows the per cent of the respondents who were "satisfied"—that is, those not adding any additional children—for each of the four possible patterns of two children, and also for the two extreme patterns of three children. From the first part of the table it can be seen that an average of 96 per cent of those wanting only two children feel they would stay with a boy-girl or girl-boy pattern, only 53 per cent would stay with two if they are both boys, and even less, 47 per cent, are content with two girls. For about half the students, then it appears that specifying a desire for two children is in actuality the same as specifying a desire for one boy and one girl. We also see from the latter part of Table 4 that 18 per cent of the students who want two children even would "try again" for a fourth child if they have three of the same sex. Thus, even today, when a decrease in family size preferences appears to be taking place, many students indicate a willingness to extend family size in an attempt to convert an

⁹ G. Myers & J. Roberts, A technique for measuring preferential family size & composition, *Eugenics Quarterly* 14 (1967) 274-81.

undesirable family sex composition into a desirable one. As parity increases, however, sex composition decreases in its influences, as individuals reach the upper limit of what is for them an acceptable family size.

Figure 2 shows, in the form of a branching tree, the proportion of students satisfied with each possible sex composition of a one, two, and three child family. The outer branches show the per cent satisfied with all-of-one sex patterns. The inner branches give the per cent satisfied with patterns of at least one child of each sex. The outer and inner branches can be compared at each parity to see the effect of sex composition on the desire to continue childbearing. The tree shows that the desire for a child of each sex is very important in deciding whether to stay with two children or go on. In fact, at low parity, sex composition desires are perhaps more important than numerical desires per se in deciding family size. Sex composition preferences, however, become less crucial with three parity, indicating the greater subjective distance between three and four than two and three for this sample. Perhaps, as Ryder and Westoff have suggested, two is viewed as representing a small family desire, and four a large one.¹⁰

It is clear that sex composition desires, especially desires for a child of each sex, may contribute considerably to maintaining the two through four child range of preferences, expectations, and actual fertility. Indeed, family size and family composition are, for the least a substantial proportion of young adults, two interrelated dimensions. Whereas family size preferences set an upper limit and a "desired range," compositional goals are perhaps a major determinant of where a

couple's performance will fall within that range. This has the following implications for fertility and family-related theory and research.

1.) Because a fairly large proportion of young adults seems to conceive of preferred family size in terms of a flexible range within which various childbearing patterns are acceptable, researchers might do well to frame questions on preferred family size in terms of minimum and maximum size acceptable rather than a rigid "how many."

2.) At least minimal data on sex composition desires also should be collected as this is potentially a major determinant for many of where actual fertility will fall within the desired range.

3.) As having children of each sex is important to the majority of young people, yet only half of all couples can expect to reach this goal in having the ZPG (zero population growth) ideal of two children, it is perhaps unlikely that U.S. fertility will drop to this level without either an extensive revamping of desires or the technological development of new methods for sex control.

4.) More research needs to be done to explore the varying functions of boys and girls to family happiness, to seek alternative explanations for the two through four child preference range and the tendency toward bimodality of desires within that range, and to determine how all these interact in the family itself and in the aggregate to produce the "average American family."

¹⁰ Ryder & Westoff, 8.

(Tables Follow)

TABLE 1A

Mean Number of children Desired, by Sex of First Two Births

<u>Sex Composition</u>	<u>Mean Number Desired</u>
BB	3.3
BG	3.1
GB	3.1
GG	3.5

TABLE 1B

Mean Additional Pregnancies since the Birth of the Second Child,
by Sex of First Two Births

<u>Sex Composition</u>	<u>Mean Additional Pregnancy</u>
BB	.56
BG	.50
GB	.43
GG	.56

SOURCE: Tables 106 and 107, page 206, The Third Child, by Charles F. Westoff, Robert G. Potter, Jr., and Philip Sagi, Princeton: 1963.

TABLE 2

Number of Children Desired*

<u>Desired Number</u>	<u>Per Cent</u>
0	5
1	1
2	47
3	19
4	21
5	1
6	3
7	0
8	3
	100
	N=73

*Responses to the question, "If you could have as many children as you want and then stop, how many children would you have?"

TABLE 3

Childbearing Patterns Desired by at Least Five Per Cent of All Students

<u>Pattern</u>	<u>Per Cent</u>
One boy, one girl	42
Two boys, two girls	19
Two boys, one girl	18
None	5

N=73

FIGURE 1

Below are some patterns of childbearing which might someday apply to you. Going from left to right represents order of birth, with the oldest child on the left and the youngest child on the right. Think about each family pattern and decide how many more children, if any, you would want in each case, and whether you would want more boys, more girls, or more of both. Then record a "B" for each additional boy and a "G" for each additional girl child you would want to complete each family pattern. If for any case you would want no additional children, place an X in the box marked "no more".

- | | | | | | | | |
|-----|------|------|------|---|---|---|------------------------------|
| 1. | Boy | Girl | Boy | — | — | — | <input type="text"/> no more |
| 2. | Girl | — | — | — | — | — | <input type="text"/> no more |
| 3. | Girl | Girl | — | — | — | — | <input type="text"/> no more |
| 4. | Boy | Girl | — | — | — | — | <input type="text"/> no more |
| | Girl | Boy | Boy | — | — | — | <input type="text"/> no more |
| 6. | Girl | Boy | — | — | — | — | <input type="text"/> no more |
| 7. | Boy | Boy | Girl | — | — | — | <input type="text"/> no more |
| 8. | Boy | Boy | — | — | — | — | <input type="text"/> no more |
| 9. | Girl | Girl | Girl | — | — | — | <input type="text"/> no more |
| 10. | Boy | — | — | — | — | — | <input type="text"/> no more |
| 11. | Girl | Girl | Boy | — | — | — | <input type="text"/> no more |
| 12. | Boy | Boy | Boy | — | — | — | <input type="text"/> no more |
| 13. | Boy | Girl | Girl | — | — | — | <input type="text"/> no more |
| 14. | Girl | Boy | Girl | — | — | — | <input type="text"/> no more |

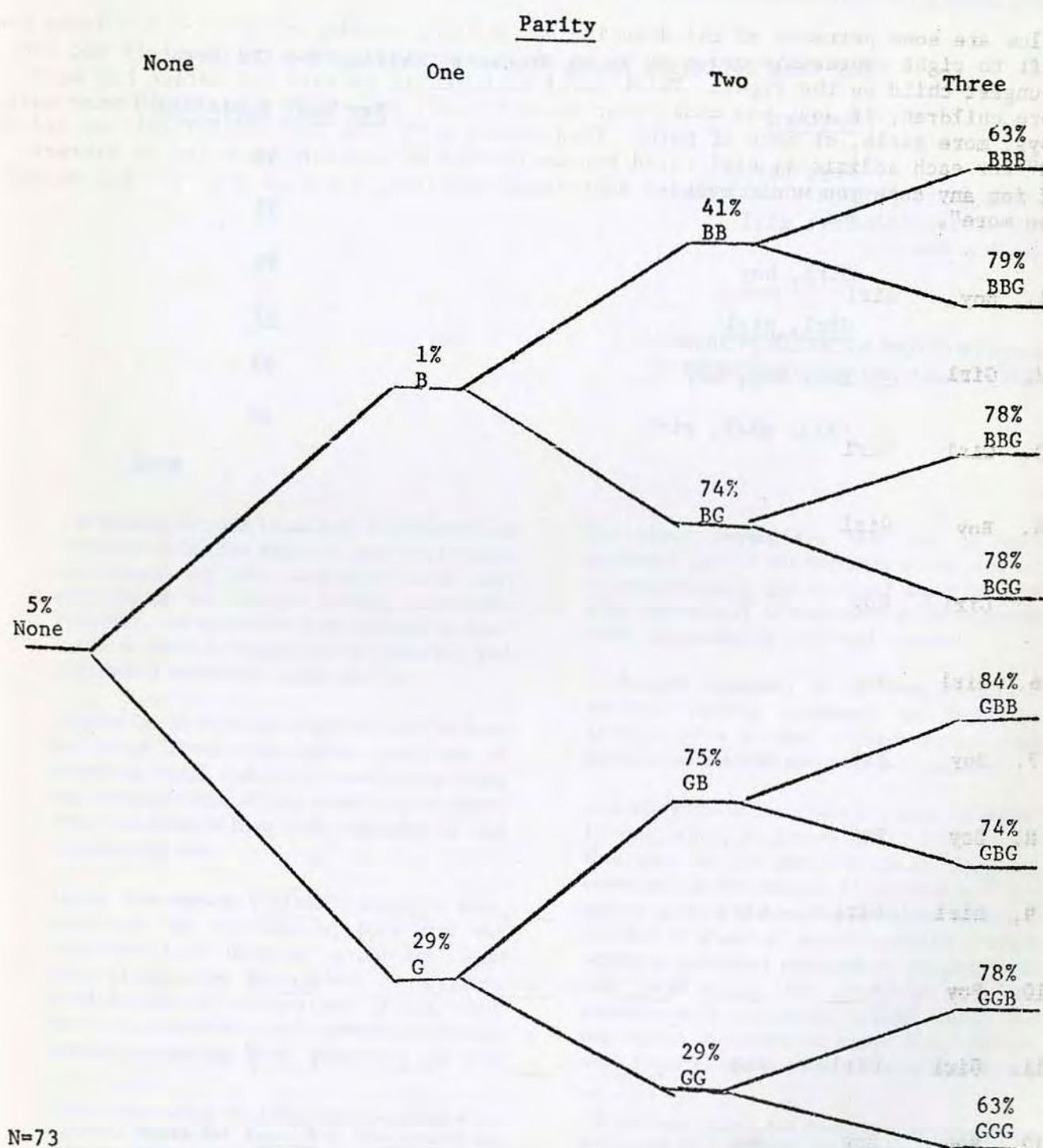


FIGURE 2

Per Cent Satisfied with Each Pattern of One, Two, and Three Parity

FIGURE 4

Per Cent Satisfied Among Students Desiring Two Children

<u>Pattern</u>	<u>Per Cent Satisfied</u>
Boy, boy	53
Boy, girl	97
Girl, boy	94
<u>Girl, girl</u>	<u>47</u>
Boy, boy, boy	82
Girl, girl, girl	82

N=34

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CHARACTERISTICS & MOTIVATIONS OF WOMEN RECEIVING ABORTIONS

The recent increase in support for reform and repeal of restrictive abortion laws has focused attention on the characteristics and motivations of women seeking abortions. However, the restrictive laws themselves have made it virtually impossible to describe that population accurately until now.¹

Studies based on illegal abortion patients have suffered from unavoidable problems of sampling, which make their conclusions about the characteristics of the abortion population even less reliable than their estimates of that population's size.

Under the various "liberal" abortion laws, such as the Scandinavian laws and the American Law Institute model law, legal abortions are restricted to certain health-related categories. Thus, only abortion-seekers who can successfully present themselves within those categories fall into

the study population. Not only is some unknown part of the population screened out of such a sample, but that part which does get into the sample is constrained to represent itself according to the legal criteria.

A further difficulty in previous studies of women seeking abortions has been the absence of a relevant control group, with which abortion-seekers could be compared.

A study without these biases is now possible Hawaii, which in March, 1970, became the first state in the nation to allow abortions essentially at the request of the woman.² The state's relative geographic isolation makes it possible to study all abortion-seeking women within a delimited population. According to the new state law, abortions must be performed in hospitals, which makes the population accessible for study. Since the law only requires the woman to meet conditions

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¹ For a comprehensive review of abortion research, see D. Callahan, *Abortion: Law, Choice & Morality* (New York: MacMillan, 1970).

² The new Hawaii law makes abortion legal if it is performed by a licensed physician in an accredited hospital, if performed before the fetus is viable outside the uterus, and on a woman who has been a resident of the state for ninety days or more immediately prior to the abortion. The only other legal restriction (not contained within the "abortion law" but within the "medical practices" act) is that anyone under the age of majority (20) must have parental consent for medical and/or surgical procedures.

or residence and length of gestation, but does not in any other way restrict the criteria for the abortion itself, most of the usual biases of presentation are absent.

METHODS

This paper is based on data from a pilot study³ using a self-administered questionnaire given to patients at two large medical facilities in Honolulu* during the period from June 1 to July 15, 1970. The questionnaire was given to all abortion patients at hospital admission, and was filled out by the patient prior to the abortion. The same questionnaire was filled out by maternity patients on the first or second post-partum day. Participation by all patients was voluntary.

Although the questionnaire was designed to reach every woman admitted to the two participating hospitals for either an abortion or a delivery during the data collection period, there were two groups for whom questionnaire data are not available: those who refused the questionnaire, and those who were inadvertently missed.

³ The data presented below were collected as part of a wide-ranging study of pregnancy, birth control and abortion, which is being conducted through the auspices of the University of Hawaii College of Health Sciences and Social Welfare. An allocation from the Hawaii State Legislature to the University of Hawaii School of Public Health facilitated initiation of the study, and a supplemental grant from the Population Council supported data collection during the first year. The study is designed to permit systematic comparisons among various groups in the pregnant population: women who attempted to prevent pregnancy; women who did not attempt to prevent pregnancy; women carrying pregnancy to term; and women terminating pregnancy by abortion.

Data are being collected throughout the State of Hawaii on abortion patients and a control sample of maternity patients, from hospital charts, self-administered questionnaires, and in-depth interviews. These three instruments provide extensive information on the medical, demographic, psycho-social and attitudinal aspects of legal abortion, within the broader context of alternative outcomes of pregnancy.

*These two hospitals represent 74.5% of the abortions reported in the state.

Usable questionnaires were received from 400 maternity patients and 272 abortion patients. There were 56 refusals, of which 25% (14) were maternity patients and 75% (42) were abortion patients. This represents a 97% return rate for the maternity sample, and an 87% return rate for the abortion sample. Tabulation of the demographic data from hospital charts for those who refused the questionnaire reveals no major differences between respondents and non-respondents in either the maternity or the abortion population. Those who were inadvertently missed in the questionnaire administration likewise appear to be a random selection.

RESULTS & DISCUSSION

The reasons most often cited by abortion patients as the major cause of terminating their pregnancies were (1) "I am not married," (2) "I cannot afford a child at this time," (3) "A child would interfere with my education," (4) "A child would interfere with my job or other activity," and (5) "I think I am too young to have a child." (See Table I)

These reasons suggest that abortion-seekers do not want to carry their pregnancies to term because they do not meet certain standards of marital status, income, occupation, or age. A comparison of maternity and abortion patients reveals that abortion patients actually do meet these demographic and social standards to a considerably lesser degree than maternity patients.⁴

⁴ The maternity data are from patients in the hospital for delivery during June-July 1970, who became pregnant too soon to have been eligible for legal abortions in Hawaii. The comparison is thus between those who obtained abortions when they were legally available locally to most pregnant women, and those who did not obtain abortions when they were available (1) illegally locally, (2) legally under rare circumstances locally, and (3) legally at considerable expense outside the state or the country. This comparison will provide the base-line data for a future report on whether legalizing abortion actually makes the service available to a larger population of abortion-seekers.

The mean age of the abortion population is 22.5 years, as compared with 24 years for the maternity population. However, 55% of the abortions were first pregnancies, as compared with 38.7% of the maternities. Taking only the first pregnancies among the two populations, the abortion group is still consistently younger. Among 155 first pregnancies in the abortion population, the mean age was 20, while for 150 first pregnancies in the maternity population, the mean was 22 years.

The age distribution of the abortion population shows an extremely high mode at age 20. While this might be actual, it does appear to reflect the legal requirement of parental consent for surgical procedures performed on minors (the age of majority in Hawaii is 20). Thus, the two-year age difference in the mean age of first pregnancy maternity and abortion patients represents the minimum age gap between the two. Depending on the size of the group whose actual age is lower than that reported, the abortion population may be even younger in relation to maternities. In either case, it is clear that those women who abort their first pregnancy tend to become pregnant at an earlier age than those who carry their first pregnancy to term.

The largest single occupational category reported by abortion patients was "student." This corroborates the finding that interference with education was the third most commonly reported reason for having an abortion. Of the abortion patients, 41.5% reported current employment. If those students who did not report current employment were added, probably well over half of the abortion patients were engaged in non-domestic activities. By contrast, only 19% of the maternity patients were employed. Nearly half of the maternity population reported their usual occupation as housewife, while only 16.2% of the abortion patients reported that they were housewives. Thus, it is clear that a much higher proportion of maternity patients are already in the occupational position most easily adapted to childbirth and infant care, while a high proportion of abortion patients are

committed to activities outside the home which would be interrupted or curtailed by childbirth.

Financial reasons for abortion are substantiated by the income distribution comparisons, which show a higher proportion of abortion patients than maternity patients in the lower income brackets. Moreover, the proportion of abortion patients in lower income brackets is more than that of the state income distribution; thus, abortion patients are not only less affluent than maternity patients, but also when measured against the state as a whole (See Table II.)

The great majority of the women under 21 in both the maternity (63%) and abortion (86%) populations were unmarried at the time of conception. For the young woman in this position, there are three possible alternatives: marriage, to legitimize the birth of the child; bearing the child out - of - wedlock; or abortion. Within the maternity population, half chose the first alternative, and married before the child was born, while the other half remained unmarried when the child was born.

The higher proportion of abortion patients giving the reason "I am not married" for having an abortion indicates that these women either were unable to marry, or refused to allow pregnancy to become the reason for marriage. At the same time, they also rejected the alternative of bearing a child while unmarried.

The percentage of single (never-married) women drops rapidly with age in both populations, but more rapidly among maternities. After the age of 25, the difference in the percentage of married women between the two populations is largely accounted for by a much higher proportion of separated, divorced and widowed women in the abortion group. (See Table III.) Overall, 87.2% of the maternity patients were married at the time of delivery. Thus, the women who carry their pregnancies to term seem to have relatively stable family situations into which to bring

children, while abortion tends to be chosen by women who do not have those family conditions.

CONCLUSIONS

Demographic and social characteristics of abortion patients have been compared with those of a control group of maternity patients, to determine whether the reasons for abortion reflected the abortion-seekers' actual social condition. The reasons given by abortion patients pointed to factors of age,

occupation, marital status, and income, all of which relate to the capacity to provide a satisfactory environment in which to raise a child. The maternity and abortion samples reveal clear differences on these criteria. Overall, the women carrying their pregnancies to term are in a better position to provide a stable home for a child than are the abortion patients. It appears that abortion patients are objectively evaluating their own capacity to provide for a child, and are making a decision that is not only in their own interest, but also in the best interest of the potential child.

(Tables Follow)

TABLE I
REASONS MOST FREQUENTLY CITED BY ABORTION PATIENTS
(Up to three reasons per respondent coded)

Reason*	No.	% of Patients
I am not married.	116	36.0%
I cannot afford to have a child at this time.	83	25.7%
A child would interfere with my education.	50	15.5%
A child would interfere with my job or other activity.	39	12.0%
I think I am too young to have a child.	30	9.0%

*Other possible choices were "I want more time between children;" "a child would interfere with the father's education;" "I already have enough children;" "a child would interfere with the father's job or other activity;" "I was raped;" "the father is a blood relative;" "my husband is not the father;" "I am concerned about over-population;" "my marriage is too shaky;" "I do not want to have any children at all;" "my parents do not want me to have the child;" "I feel that I am not physically strong enough to have the child;" "medical (please give reason)" and "other (please give reason)."

TABLE II

FAMILY INCOME OF MATERNITY & ABORTION PATIENTS, COMPARED WITH
STATE INCOME DISTRIBUTION*

	Maternity	Abortion	State Distribution
Under \$6,000	27.7%	37.4%	18.4%
\$6,000 - \$9,999	33.9%	28.7%	22.9%
\$10,000 & Over	38.3%	33.9%	58.7%

*Data on state income distribution calculated from Table 47,
U.S. Department of Commerce, General Social & Economic Charact-
eristics, 1970, PC (1)-C13, Hawaii.

TABLE III

MATERNITY & ABORTION PATIENTS' AGE
& MARITAL STATUS AT CONCEPTION
(By Percentages)

	Under 21	21-25	26-30	31-39	40+
M					
A Single	63%	22%	2%	6%	14%
T					
E Married	36%	76%	96%	88%	72%
R					
N Separated/ I Divorced/ T Widowed Y	1%	2%	2%	6%	14%
A					
B Single	87%	63%	27%	10%	0%
O					
R Married	12%	27%	57%	71%	75%
T					
I Separated/ O Divorced/ N Widowed	1%	10%	16%	19%	25%

THIS IS
 A CERTIFICATE OF ADOPTION
 OF THE
 RESOLUTIONS OF THE
 BOARD OF DIRECTORS
 OF THE
 COMPANY
 DATED
 1911

No.	Name	1911				Total
		Jan. 1	Feb. 1	Mar. 1	Apr. 1	
1	John A. Smith	100	100	100	100	400
2	John B. Smith	100	100	100	100	400
3	John C. Smith	100	100	100	100	400
4	John D. Smith	100	100	100	100	400
5	John E. Smith	100	100	100	100	400
6	John F. Smith	100	100	100	100	400
7	John G. Smith	100	100	100	100	400
8	John H. Smith	100	100	100	100	400
9	John I. Smith	100	100	100	100	400
10	John J. Smith	100	100	100	100	400

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NORMATIVE VIEWS OF DOCTORS & NURSES ON ABORTION

Doctor and nurse relationships reflect a long history of conflict between the two occupational groups. The basis for some of these conflicts have been reviewed by many (Argyris 1955, Burling & Wilson 1956; Corwin & Taves 1963; Reissman & Rohrer 1957; Titus 1952). Doctors have been of the opinion that nurses should be handmaidens of the doctor. This belief has been somewhat modified (although not discarded) as nurses demonstrate their increasing technical competence in new technology, demand their 'place in the picture' and exercise 'nurses power.' Nurses have been of the opinion that physicians should be concerned with the total care of patients, not just the physical condition under treatment. Studies of medical training programs suggest only limited concern for the 'total patient care' approach. Coe (1970) and Freidson (1970) provide some review of this approach in medicine. One basis for conflict between nurses and doctors is that role expectations for each group have been defined differently by the other occupation. The concern of this paper is

to examine the conflicting normative views of doctors and nurses on a highly controversial medical treatment, abortion.

This paper is a descriptive report of how nurses and doctors in two large urban hospitals reacted to and interacted with each other when abortion laws were changed to include a broad definition of mental health as a legitimate rationale for abortion.¹ Both hospitals were immediately involved in determining legal procedures, provision of hospital facilities and adoption of minimal professional guidelines for all personnel involved.

¹ These findings are drawn from a current study by this author examining medical functionnaires' attitudes and behavior on many aspects of abortion. These tentative findings represent the initial phase of the study which included identifying the issues and conflict between the nurses and doctors involved in hospital abortion treatment. The interest for this study arose from a graduate seminar taught by this author to a group of faculty in a nursing school. Since this author is a registered nurse as well as a sociologist, access was available to study these changing conditions in several hospitals. Since the anonymity of the hospitals and staff must be protected, it is not possible to directly acknowledge their assistance and continued interest in this study. There is no reason to believe that the doctors and nurses in this study differ from those in the larger population on factors such as age, length of time in specialty, marital status and religion.

This is a slightly revised version of a paper presented at the annual meeting of the Southern Sociological Society, 1971. Partial support for this research was provided by the George Washington University, Washington, D.C. The author is grateful to Dr. George Weber, National Institute of Mental Health, for helpful suggestions on the first draft of this paper.

Since patients were available immediately and putting pressure on physicians for abortions, the doctors pressured hospital administration to 'open the gates.' There was little time for defining treatment boundaries, specific role expectations and performances for nurses and doctors.² What resulted was a change in a short time period from approximately thirty abortions a month to over two hundred at each hospital. However, legal consent was cautiously evaluated by both hospital administrations. Thus, specific legal procedures were established before mass abortions could be performed.³ The previously mentioned conditions would likely

² Both hospitals were the focus of community protest activities with attempts made to slow down hospital operation by sit-ins. These, while a nuisance to the administration because of the unfavorable publicity, did little to slow the abortion activity. However, the administrations of both hospitals did indicate that protest activities tended to heighten the need for legal safeguards and protection for the hospital. Another form of protest was found by McDermott and Char (1971) who reported in their study of abortion repeal in Hawaii that nurses seemed to resent the increased work load that accompanied the changes in the abortion law. The liberalization of the law resulted in a flood of abortion activity. Combat fatigue and the dislike of hospital images as slaughterhouses or abortion factories resulted in the nurses protesting the increased abortion in the hospitals.

³ Several nurses who disapproved of abortion indicated that they could 'bug' the physicians by preventing patients from going to the operating room if any technical question could be raised on the legal consent signed by the patient. Obviously this irritated the physicians who knew the game being played. The nurses also complained that legal regulations were rigid and complicated and required at least 15-20 minutes of a nurse's time per patient to determine if all legal requirements had been met. Eventually, through the nurses' protest to administration, the legal consent and the written history and physical forms became the responsibility of the physicians for placing on the patient's chart before surgery. It is interesting to note that the physicians refused to put the history and physical forms on the charts until the patient was in the operating room. They reported they did this to protect the patients since nurses often gossiped about patients sexual and personal histories,

produce conflict for the occupational groups involved, since the situation changed from strict norms prohibiting abortion procedures to relatively few norms on procedures for abortion.

METHOD

Data for this exploratory study were collected from (1) many informal conversations with hospital personnel, (2) observations in two large urban hospitals over a period of nine months, two days a week, and (3) over sixty in-depth interviews with physicians and nurses. The informal conversations developed from a graduate seminar with nurses in one of the participating hospitals. The nurses were greatly distressed over the rapid increase in abortions performed for the diagnosis 'pregnancy with depression.' It was from this seminar that the study was initiated. When talking separately with and observing interaction between the nurses and physicians on the issue of abortion, it became very apparent from both groups that this was a 'marriage on the rocks.' When discussing with doctors some of the general problems associated with the increase in hospital abortion activity they immediately wanted to talk about the confrontations between themselves and the nurses. The following responses made by physicians during the informal observational period support a basis for conflict.⁴

"Nurse should give more TLC and let the doctors determine how to treat the patients."

"Nurses have one major job; to do what the doctors tell them to do."

"Nurses should do their job and let others do theirs. It is not the nurse's prerogative to be defining the doctor's role for him."

"Nurses think we are not doing our job by just aborting patients. But they want

⁴ The quotations used in this paper are offered as illustrations of the typical response from the representative group described, e.g., doctors and nurses. They are not the total responses offered but are samples that show the direction of attitudes held by each group.

to save the whole world instead of limiting their attention to the hospital needs."

When discussing matters of abortion with nurses their initial responses focussed on negative options about their experiences with doctors, not specifically whether or not they approved of abortion. The following nurse responses during informal conversations suggest conflict between the two occupational groups.

"The doctor's attitude is most significant and how they do them. (abortions)."

"Doctors don't understand our problems. A patient aborting in bed in the middle of the night after a saline injection is most distasteful. It upsets the other patients to see someone running out of the room with a fetus in a bottle."

They (doctors) don't care about mixing patients in the same room. They put 'salines' in the same room with stillborn patients and miscarriages."

"Doctors shouldn't do hysterotomies. Sometimes they get a viable fetus who has to go to the nursery in an incubator and be treated as a newborn. Also the patient has to pay a lot of money for that nursery care. My roommate was involved in a dispute with a resident who drowned a live baby after a 'saline' treatment."

"Doctors should do more than just abort these women. Followup care should be available and required for all women who end up in the dilemma. The doctors must take the initiative in this regard, but they don't and probably won't."

The initial impressions from observations in both hospitals indicated great differences between physicians and nurses on their normative views on abortion. These preliminary observations lead to the gathering of further data by in-depth interviews with over sixty physicians and nurses working in these hospitals caring for abortion patients. In addition, nurses working in the operating room and recovery rooms were included in the sample. Because of the difficulty of changing time schedules of nursing personnel, and my limited schedule it was not possible to

select randomly the sample to be interviewed or observed. However, the intent of this study was not to test hypotheses or generalize beyond these groups but to explore and identify phenomena, at least to some extent, surrounding the conflict between physicians and nurses on the issue of abortion. Careful attention was given to checking reliability and validity of the responses from those persons interviewed.

The remainder of this paper will describe differences on abortion issues between doctors and nurses as these were identified from the interviews and observations in the two hospitals studied. The following major areas are explored: 1) 'definition of the situation'⁵—abortion defined, 2) and normative concepts of treatment.

DEFINITION OF THE SITUATION: ABORTION DEFINED

In general the doctors interviewed (N=28) favored abortions as an acceptable treatment for eliminating unwanted pregnancies for all women. However, while many doctors favored the treatment they performed the treatment for select patients only. These doctors indicated they did abortions for their established clientele or for children of former patients. They did not consider the 'abortion trade' a desirable clientele. Physicians who performed many abortions defined unwanted pregnancy as a personal problem for a girl who is 'in trouble' and needs help. This is a difficult definition to apply to women who are married but the doctors agreed that 'in-trouble' did not apply only on a moral basis. If a pregnancy is unwanted (regardless of cause or marital status) there needs to be an immediate deadline within which to solve the problem of terminating pregnancy. This constitutes the nature of trouble as well as the familiar moral connotation that the girl has been bad.

The basic solution for a girl with a personal

⁵ This concept was coined by W. T. Thomas in *The Unadjusted Girl*.

problem, unwanted pregnancy, is a short range solution, abortion. Some of the physicians defined the solution to the problem in this manner because they considered the girl who was 'in trouble' to be promiscuous. They argued that promiscuous women should not be allowed to become a burden to society by producing many illegitimate, unwanted children. However, they indicated they disliked doing abortions for patients they felt were promiscuous. Curiously enough they defined abortion as punishment for these women. The nature of this punishment was attitudinally expressed to patients.

"I used to think these girls (patients requesting abortion) were nice girls but I'm finding out they are really promiscuous. So why tell them anything. It's too late for them to have any help."
 "These girls should be sterilized after abortion. There is no hope for them. Nice girls don't get into this mess."
 "My patients want their babies. Something is wrong with a woman who doesn't."

These quotations illustrate several ideas. Nice girls don't request abortions. Girls that do want to terminate their pregnancy are probably promiscuous. Furthermore the physicians who felt many patients were promiscuous indicated that any treatment besides surgical termination of the pregnancy would be useless. The following responses were representative of the physicians who defined abortion as a personal problem to be solved by one short range solution, abortion.

"Follow-up care may be important but that isn't our task. Besides, I used to lecture patients on morals because in my generation your conscience dictates you should. But after awhile it falls on deaf ears and to be practical you don't waste your time."
 "Unwanted babies end up in orphanages if they are lucky or ghetto climates if they aren't. These children when older end up 'in-trouble' if females, or cause society trouble, if male. Why should bad women produce more bad babies."

The nurses interviewed (N=37) defined abortion differently from doctors. Abortion was a social problem which they felt was likely to increase. The solution to a social problem, unwanted pregnancy, was impossible by surgical procedure. More important to all the nurses were the social well-being and total care of patients with unwanted pregnancy. Abortion was considered detrimental to the social well-being of the patient. However, most of the nurses interviewed had to cope with resolving their conflicts while caring for patients receiving abortions. They indicated that they did attempt to provide patients counseling opportunities for determining the cause of the unwanted pregnancy. Thus, even though almost all of the nurses disapproved of abortion for themselves, they attempted to maintain their professional responsibilities to the patients by suggesting and providing further emotional guidance after the procedure.

Many nurses did indicate that in their view quite a few of the patients had been promiscuous but punishment was not in order. More important to the nurse was the mandate to educate, prevent and correct the behavior. Nurses stated that these should be the basic concerns of the doctors performing abortion. The following responses summarize the predominant concerns of the nurses.

"Doctors should do more than just abort these women. Follow-up care should be available and required for all women who end up in this dilemma. The doctors must take the initiative in this regard, but they don't and probably never will."
 "In too many cases abortion only heightens the patient's problems. In the short run it saves them some suffering. In the long run the damage and scars will remain. We think we are a liberated society, but even for the college girls caught up with the mod scene psychiatric problems are likely to develop later. You can't kill something in your body and forget about it very easily."
 "We have tried so hard to bring the doctors around to the position of

requiring follow-up care for their abortion patients. We have failed to convince them that this is important. We could accept the idea of abortion easier if we knew the doctors were more interested in their patients' total well-being."

The second major area explored in this paper is the differences between physicians and nurses on concepts of treatment.

NORMATIVE CONCEPTS OF TREATMENT

Pre-Surgical

As mentioned in the above section, more doctors favored surgical termination of unwanted pregnancy than opposed it. This is also consistent with recent poll reports analyzing doctors' views on abortion, (cf Smith et al., 1970). Less consensus existed on whether or not pre-surgical treatment should include psychiatric evaluation and consultation. Many physicians responded that they were unable to treat totally 'pregnancy with depression.' This diagnosis covers 95% of all abortions performed in the two hospitals studied and in the larger society as well. In addition, the physicians did not feel it their responsibility or capability to discuss any treatment alternatives with patients holding this diagnosis. They argued further that since they did not make the diagnosis they were not responsible for treating this condition. Promiscuous women who wanted to terminate unwanted pregnancy did not qualify by these physicians for the diagnosis, pregnancy with depression.

"If you were sixteen, pregnant with no parents and no job, wouldn't you be depressed? What can you do but perform an abortion and hope never to see her again. I tell my patients, don't come see me again. You should learn your lesson this time."

"A minister or priest can't help them now. I have no right to suggest any directive for help other than what I give in the operating room. Doctors would never see all their patients if they spent a

lot of time lecturing patients. Let the nurses do it. Then maybe they will realize they can't save everyone."

"When a girl doesn't want to carry her pregnancy she goes to a doctor to pull it out, just as the patient with an impacted wisdom tooth. All that matters to the patient in both cases is to get rid of the problem."

A few doctors indicated that careful psychiatric diagnostic examination be completed before the surgical treatment is performed. However, these physicians were also quite conservative in their approach to abortion such that they performed abortions only on highly selected patients. These patients were generally children of their regular patients. Most of the physicians agreed that abortion was necessary in cases of incest, rape, possible genetic deformity, and in cases of interracial pregnancy. Pre-surgical treatment in the form of counseling was unnecessary for these patients. Immediate abortion was the only solution to the problem.

"I had a 10 year old girl in my office recently who was pregnant by her uncle. What is there to say to a girl in a case like that. You give her tender loving care (TLC). You can't even give birth control pills in that situation."

The nurses who were interviewed were generally in consensus in both hospitals. They did not approve of the image the two hospitals were acquiring, 'abortion mills.' They did not approve of abortion on demand. Many of the abortions performed were for patients who did not live in the state. These patients were hospitalized for a short time only because they were anxious to return home. There was little time for contact with these patients by doctors or nurses. Pre-surgical care often included the nurse going to the airport to meet the patient, obtaining the necessary history, consent, fees, etc. during the ride back to the hospital from the airport. This type of pre-surgical care was considered inadequate by the nurses who felt the doctor should explore all alternatives with the patient before performing the abortion.

Adoption was one suggested alternative by nurses but often rejected by physicians who argued the psychological trauma associated with giving up a baby after carrying it full term was higher than that associated with abortion.

"How can the real psychiatric condition of the mother be determined in a ten-minute ride? How do you determine her past history of coping with problems? My roommate works for a physician who performs at least 45 abortions a month—most of them are out of town patients. She spends much of her time at the airport. We call him the 'abortion king.'"

Very few (2) of the nurses interviewed indicated religion to be a significant part of their opposition to abortion. The physicians' management of the problem was at the basis of their disapproval. Many indicated that if a careful consultation system could be developed whereby a serious effort was made to determine the real psychiatric condition of the mother, they would have more faith in the physicians. The nurses reported that the psychiatric evaluations brought in by the patients were almost carbon copies and appeared almost mass produced. Patients would tell the nurses that all a patient needed to do was tell the psychiatrist, "I am pregnant and don't want my baby. I am going to kill myself if I can't have an abortion." The patients reported to the nurses that no attempt was made by the psychiatrist to explore why this condition existed, examine any alternative solutions or any recommendation for post-surgical psychiatric follow-up.

Further concern to the nurse was the 'repeater' patient. If patients were given adequate pre-surgical psychiatric evaluation a basis for evaluating the pattern of recidivism could be developed. Most of the nurses in both hospitals greatly disapproved of the patient having a second or third abortion. Many of the patients were college girls who voiced no concern about prevention of unwanted pregnancy. This irritated the nurses who reasoned that repeaters are promiscuous

girls. The availability of abortion on demand would heighten free sexual behavior and sexual behavior without responsibility. This would continue to be treated by abortion and no stabilization of abortion rates would occur.

"When a patient tells me she doesn't care whether or not she gets pregnant since she can always get an abortion, I close my ears to her. She soon gets the point that I don't approve of her nor do I like her. Many of our young 'mod' college girls think it is chic to have an abortion. Someday I believe they will regret this behavior and attitude."

Surgical care or abortion procedures are not discussed in this paper in detail since there are many possible procedures involved. However, the basic concerns of the nurses were the dislike of 'saline injection' procedures and the hysterotomy procedure. In the former, the procedure to nullify the fetus requires approximately 20 minutes. The delivery or labor time for expulsion of the fetus ranges from 12-20 hours. Many nurses refused to assist the physician in the procedure but would care for the patient during the delivery phase. Even more disapproval by nurses centered around the procedure hysterotomy. This involves an abdominal incision such that the fetus can be directly removed from the uterus. As mentioned previously some viable feti have been removed. The problems resulting from this are too difficult in scope to examine in this paper. The basic difference between nurses and doctors on choice of technique resulted in considerable overt conflict to the extent that many nurses refused to assist in these procedures. Problems in adequate staffing of nurses were immense and were not solved at the time of study.

One interesting similarity between doctors and nurses was their attitude on sterilization. Both groups objected to the 'repeater.' If a girl doesn't learn her lesson the first time, when she gets her second abortion she should be sterilized. In fact some doctors told their patients that they would perform an abortion only if the patient consented to sterilization.

"Education is obviously not the answer for these women. Birth control instruction, even the pill doesn't work. They are irresponsible promiscuous women who will never learn."

The nurses echoed this attitude. Neither group was tolerant of the abortion repeater. The implications of this attitude will be explored in another paper by this researcher.

Post-Surgical

Many of the physicians interviewed said they routinely gave birth control information to patients after performing the abortion. However, they qualified their responses by adding that they didn't feel it did any good. The patients who did return for another abortion obviously had not heeded the instructions. The other patients did not call for renewal of the birth control pill prescription. This may be explainable by the large number of non-resident patients. In general the physicians agreed that follow-up psychiatric care for their patients was not required or even desired. If these patients were 'in trouble' because of promiscuous behavior little could be accomplished by requiring a follow-up visit to the psychiatrist. The physicians indicated that the nurses really had a problem themselves since they pressured the doctors to require a psychiatric follow-up visit.

"These nurses are too moralistic and have their halos screwed on too tight."

"Nurses should give tender loving care (TLC) not attempt to give 'therapeutic care' in the psychiatric sense. Nurses feel they (nurses) are beyond reproach and must save everyone else. Let them spend some time with unwanted children, and they will change their viewpoint and realize they can't save everyone."

The nurses agreed strongly that psychiatric follow-up, and birth control follow-up be required for all patients. They did not approve of the lucrative intent of many of the physicians. It should be noted that

approximately 40% of the physicians on the gynecology staff in both hospitals did most of the abortions. The nurses all agreed that this was the only way some of the doctors could maintain an active practice. This was explored and found to mean: the doctors who do abortions almost exclusively are marginal in competence. In both hospitals the nurses founded a voluntary counseling group for the purpose of distributing information to the patients on birth control. They also attempted to bring the patients together on the nursing unit after surgery.

One purpose of the patient-nurse counseling sessions was to help patients examine how to prevent repeated pregnancy. The nurses reported that these counseling sessions had accomplished little since many patients did return for second and even third abortions. To the nurses this meant that the doctors had not been successful in treating the 'total' patient. This was the basic point of disagreement between the nurses and the doctors. The nurses indicated they put continuous pressure on the physicians to order follow-up care for their patients, at least the repeaters. At the completion of this phase of the study, little success in this area was visible to the nurses.

SUMMARY & CONCLUSIONS

This paper has described how doctors and nurses in two large urban hospitals 1) define abortion and 2) view the treatment process. They define the situation quite differently. Nurses view abortion as a social problem requiring long range solutions. Physicians view abortion as a personal problem requiring a short range solution. Physicians did indicate, however, that perhaps in the future education would be necessary to prevent permissive, promiscuous behavior.

In addition, physicians and nurses disagree greatly in their views on abortion treatment (see McDermott). This conflict still persists in both hospitals although some attempts at resolution have been minimally successful. For example, responsibility for obtaining appropriate legal consent for the specific

abortion procedure was shifted by hospital administration from the nurse to the physician. This resolved two areas of conflict. First, nurses did not have to spend extra time carefully checking the legal technicalities of the consent procedure. Secondly, nurses were no longer able to annoy physicians by keeping patients from going to the operating room because of improper legal consent. This is important since at the time of study considerable time (at least fifteen minutes per patient) by nurses was spent in following the hospital rules for legal protection in each abortion performed. While patient consent is necessary in every surgical procedure and is obtained routinely without problems, the legal-illegal nature of the abortion controversy heightened the need for clarification and precision. The nurses argued that the extra work required by the physicians to obtain legal consent might eventually sensitize them to the social nature of the abortion problem. If, for example, a physician were to be prevented from doing an abortion on a married woman (living separately from her husband) because the husband's consent was required by the hospital, the physician might begin to under the 'total care' approach necessary for this problem. According to the nurses, this might eventually result in the physician 'redefining the situation' of abortion from a personal to a social problem.

Finally, this descriptive report supports the sociological literature that examines conflicts between doctors and nurses. For example, the genesis of some of these conflicts are reviewed by Corwin and Taves (1963). Freidson (1970) suggests that nurses attempt to escape subordination to medical authority by carving out some area over which it can claim control. This is demonstrated by the nurses in this study setting up voluntary counseling groups for patients on the nursing unit and also

follow up care in patients' homes. Furthermore, the movement of nurses into administration, relegation of their patient care tasks to less trained personnel, suggests to the nurses that their bargaining power with physicians is improving. While hospital nurses are dependent on physicians to provide patients, physicians are dependent upon nurses to either themselves provide competent patient care or supervise others to do the same. This growing administrative responsibility for the nurse in these urban hospitals is being perceived by the nurses as 'Nurses' power'. As nurses experience more success in administrative fields they appear to be redefining their relationships with physicians in hospitals. The nurses in this study viewed the present time as opportune for nurses to wrestle power from physicians for determining nurse role performances. The extent of this perception among nurses in general is beyond the scope of this study. However, considering general societal conditions surrounding issues of power movements and present protest movements outside the occupation of nursing, the idea of 'nurses' power is not startling and perhaps long overdue.

In conclusion, nurses and doctors in this study identified their relationships with each as 'marriage on the rocks', especially as it related to conflict on issues of abortion. One of the elements in this stormy relationship centered around nurses not accepting their subordinate role nor definition of role expectations by persons outside the nursing profession. If doctors continue to define the nurse as his handmaiden, and if the hospital nurse is unwilling to accept this definition, under conditions of the controversial treatment abortion the 'marriage on the rocks' has an unfavorable prognosis.

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